the MODERN HOSPITAL

VOLUME 67 AUGUST 1946 NUMBER 2

Sir Isaac Newton — English natural philosopher and mathematician — conceived the idea of universal gravitation after seeing an apple fall in his garden. From this he went on to prove one of the basic laws of science.

FORWARD STEPS IN SCIENCE

SIR ISAAC NEWTON'S RESEARCH WORK in the late 17th century paved the way for the tremendous forward strides made in science in the 19th and 20th centuries. So too, in the field of Surgery . . . the research work of SKLAR'S metallurgists paved the way for one of the great forward steps in surgical instrument making . . . the discovery of the proper alloy of stainless steel for use in manufacturing surgical instruments.

SKLAR'S Stainless Steel surgical instruments . . . made by expert craftsmen . . . often with the cooperation of leading members of the profession . . . give the surgeon instruments that are at once tough and resilient . . . that will not chip or corrode . . . that have balance, character, dependability.

Today J. SKLAR MANUFACTURING COMPANY makes the greatest variety of stainless steel instruments ever made by a single manufacturer. *SKLAR products are now available through accredited surgical supply distributors.*

Blade made in three sizes. Descriptive circular will be sent to interested surgeons.

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A catalogue of SKLAR Stainless instruments will be provided on request.

It is estimated that one in every fifty people in the United States is potentially a diabetic . . . that one in every two hundred fifty is already diabetic. Through prudent regulation of diet and exercise, together with appropriate doses of Insulin, these individuals may expect to lead close to normal lives.

Therapeutic response to Insulin varies with the individual patient; therefore, Iletin (Insulin, Lilly), Iletin (Insulin, Lilly) made from zinc-Insulin crystals, and Protamine, Zinc & Iletin (Insulin, Lilly) are made available in various strengths.

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THE ROVING REPORTER

Better Than a Facial

One would think that after an eight hour stretch on the wards, a nurse would just want to sink down on a garden bench, slip off her broad white shoes and sip lemonade. But that isn't the way it's done.

No less an authority than Marie Behlen, principal of the school and director of nursing at Long Island College Hospital School of Nursing, Brooklyn, N. Y., declares that the way both to prevent nervous tension and fatigue and to relieve nervous tension and fatigue is for the nurse to get right in there pitching —softballs, volleyballs or horseshoes.

So strongly does Miss Behlen hold this view and rally medical opinion to its support that student nurses under her tutelage have a year round program of supervised sports under Mrs. Olive Haring, the former director of physical education at Centenary Junior College, Hackettstown, N. Y. Mrs. Haring is in charge of all recreational and social activities of the Long Island College Hospital school.

In summer the sports program moves outdoors. Behind the hospital is a large sports area consisting of two tennis courts, a double handball court and ample space for archery, croquet, softball, volleyball and horseshoes.

When winter comes, the girls stay indoors for basketball, tap dancing, modern dancing, swimming, hockey and applied calisthenics.

Students get to pick and choose their sports for the supervised training and, of course, for free play.

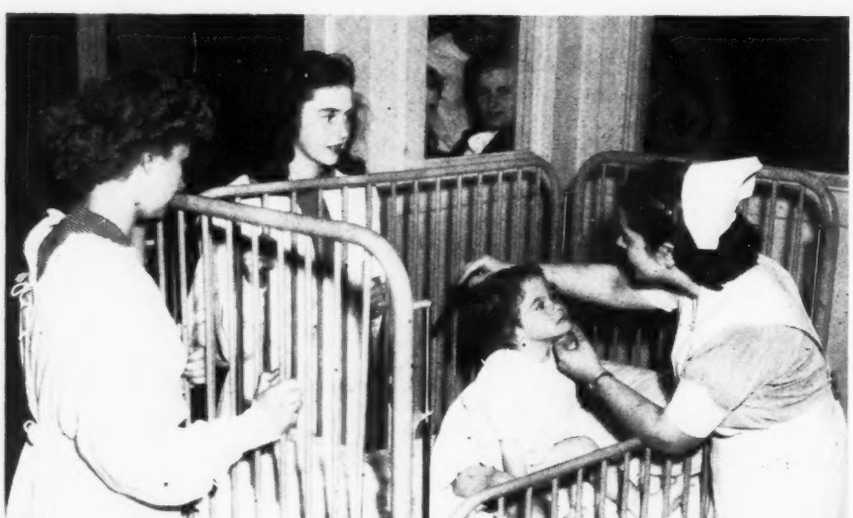
"One hour of exercise outdoors is more beneficial to the young woman than a facial or a body massage," Miss Behlen declares. And where could you get a facial and body massage in one hour—and for free?

Nurse Recruiting à la War Time

Open House Week during the war brought flocks of high school girls into the nursing schools to observe the life and times of the student nurse.

To bolster the feeble enrollments in nursing schools in general, 23 schools of nursing on Long Island repeated this wartime recruiting device to good effect. More than 1800 students from the high schools on Long Island requested tickets for the ninth semiannual Open House Week. Most of them saw a fascinating new world and a number of them—it is too soon to know how many—are deciding they would like to be a part of this world.

The Nurses Associations of the Counties of Long Island, Inc., put on a good publicity campaign for the week. Another step toward speeding up recruits for the schools was the appointment of a high school representative for student nurse recruitment in each of the 130 high schools on the island. This was made possible through the cooperation of the division of educational and vocational guidance of the board of education.



High school students are shown pediatrics ward of Long Island College Hospital during a visit to the institution as a part of Open House Week.

Letters to the P.A.

Back in '42 St. Mary's Hospital, Rochester, Minn., had a successful "war on waste" campaign. There was a war to win and all the nurses and employes, made aware of the necessity for economy, fell to and did a bang-up job in saving supplies.

"Did you know," asks the St. Mary's *News Bulletin* for employes, "that essential supplies are more critical now than at any time during the war? How would you like to keep on working in the hospital, trying to do your job well, if there were no . . .

Electric light bulbs
Paper toweling
Hypodermic syringes and needles
Cups and plates
Knives and forks
Sheets and pillow cases
Binders
Butter
Bread
Meat
Etc, etc., etc?"

On the next page, illustrated with little drawings, the hospital reproduces portions of letters received by the purchasing agent. A few samples will be quoted.

To St. Mary's Hospital:
We regret that no more electric light bulbs are available.
Electric Company

To St. Mary's Hospital:
Silver plate is unavailable. Might be out by fall but can't promise.
L.C.M., New York

To St. Mary's Hospital:
We regret that our stock of scultetus binders is exhausted. We trust that you appreciate the difficulties under which we are forced to operate today.
C. Linen & Equipment Co.

"So much for supplies," says the *Bulletin*. "Now there is that other precious commodity that we all need—time. Could it be that you take unnecessary steps and do unnecessary worrying because—

"You Don't Plan Your Work Well?"

Employes are then urged to read the following suggestions gathered from various people about the hospital, see

how many of them they can use and how many others they can add. The suggestions are as follows:

1. *"Concentrate on Saving Motions.* See how simple you can make procedures, especially those you do many times a day, by making each motion count. If you can put a sheet on a bed with three movements, don't use six. If you can serve a dish of tomatoes with two movements, don't use four.

2. *"Standardize the Placement of Equipment.* If you can go from one ward, one kitchen, to another and know exactly where to find a thermometer, a requisition blank, a paring knife, a napkin, think of the time and irritation you save.

3. *"Centralize the Placement of Articles Used Together.* If you have hot water bottles, hot water bottle covers, a graduate measure and thermometer in the same room as the water supply, you don't have to take a walk every time you fill a hot water bottle.

4. *"Have a Place for Everything and Everything in Its Place.* Maybe you think you haven't time to put some equipment away. Think of the time someone else has to spend trying to discover it.

5. *"If You Must Borrow Equipment, Return It Promptly*—and please don't lend it to somebody else; think of the original owner. (In this connection, what would you think of establishing a Borrow and Loan Center?)

6. *"Delegate Responsibilities.* Be sure everyone understands his work by having written work schedules.

7. *"Have the Right Person Do the Right Piece of Work.* If you are in charge of a unit and try to do all the details of the work yourself you will miss your real job of helping others to work effectively.

8. *"Have an Adequate Amount of Supplies and Equipment Available.* Those hours we spend—waiting.

9. *"Reevaluate Your Work and Work-Place Frequently* to make sure that you have not slipped into habits that keep you from doing your work easily.

10. *"Work Because You Want to, Not Because You Have to.* Every day is a day to be lived, not a day to be endured. Live every minute of it with enthusiasm, conscious of its eternal significance."

Is This the Fateful Year?

Can it be that certain events of 1945-46 may lead the way out of the Bedlam that broke loose in the Middle Ages never yet to be brought under civilized control—the institutional neglect (not care) of the mentally ill?

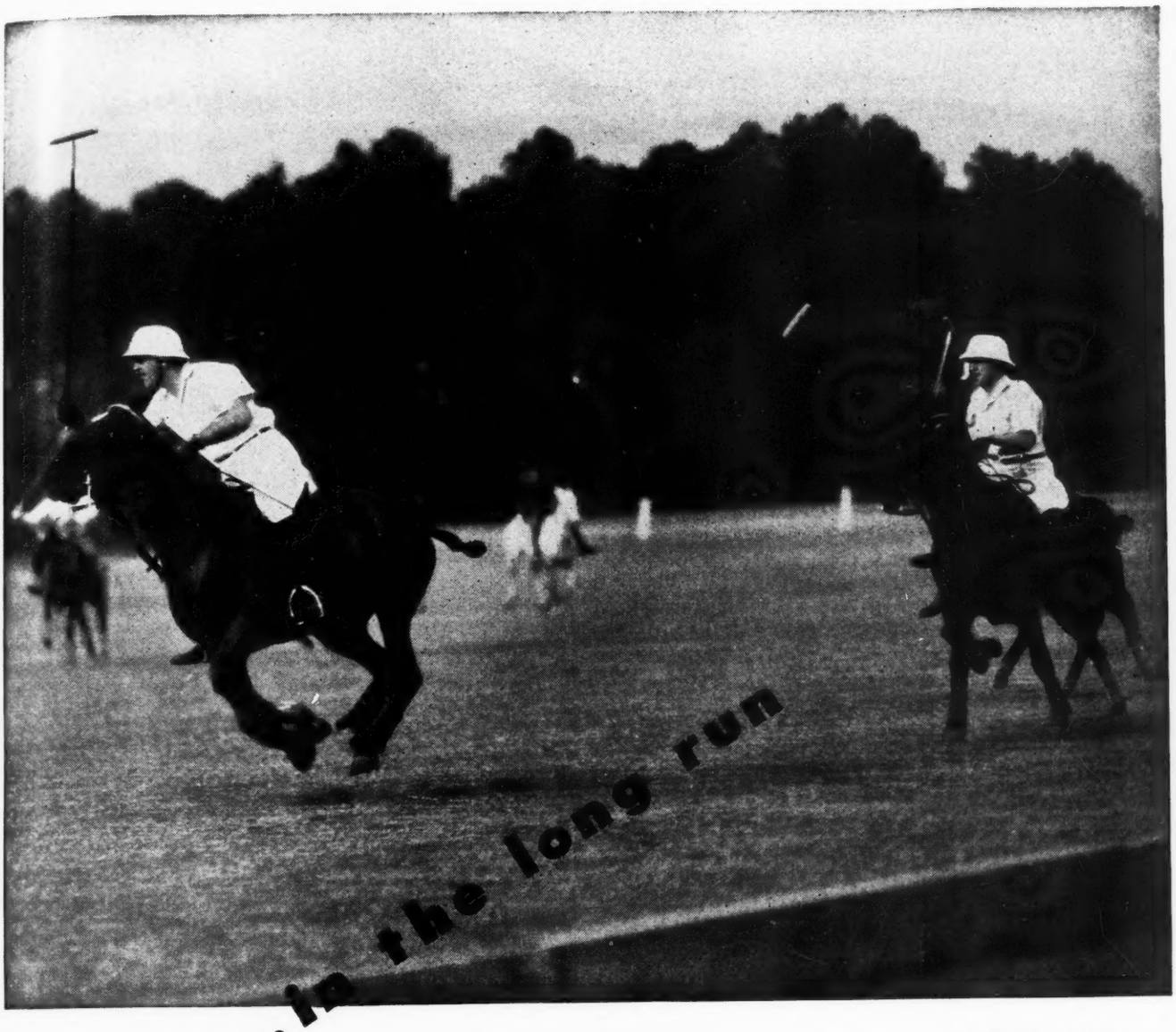
To name a few jolts to public and official complacency, there are the grand jury report of conditions in Cleveland State Hospital, formation of the National Mental Health Foundation, The MODERN HOSPITAL's dignified competition on improving the hospital care of psychiatric patients, *Life's* shocking series of photographs from mental institutions, Albert Q. Maisel's incriminating series in *PM,* Mary Jane Ward's best seller, "The Snake Pit," and her article, "Out of the Dark Ages," in the August issue of the *Woman's Home Companion.*

Can patients' relatives, the public, the psychiatrists, the mental hygienists, the administrators of both general and psychiatric hospitals remain dormant in the face of this series of graphic portrayals of conditions unfortunately more typical than isolated?

Even small gains are worth reporting as an indication of what, please God, may become a broad sweep of progress.

Take New York State, for example, where one of its newest institutions is said to be the locale of "The Snake Pit." A study at Brooklyn State Hospital proved that a group of insulin treated patients who were given adequate service by social workers had a shortened hospital stay, better adjustment to the community and greater usefulness.

Following that survey, the ratio of social workers to cases throughout the state department of mental hygiene was thoroughly analyzed and the number was increased from one worker per hundred



"It Pays to Buy the Best"

An old adage most opportune today

Acute postwar shortage of desirable merchandise makes it more essential than ever to procure, if possible, merchandise that is especially constructed and particularly adapted for efficient hospital use and economy.

For many years we have supplied dependable, high quality textile specialties to hospitals throughout the country. As previously unobtainable items become available, we shall again stock them for your service and convenience. Your inquiries are invited.

Textile Specialties

Blankets
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Gowns
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Table Linens
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Sheets
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Spreads
•
Towels
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Crashes
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Curtains
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Bed Pads
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Infants' Wear
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Rubber Sheeting
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John W. Fillman Co., Inc.

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cases outside the hospital to one per 60 cases.

Now Commissioner Frederick MacCurdy announces the awarding of eight scholarships to college graduates for study at accredited schools of social work. These young women, after three months of graduate study, will be the first student social work aides chosen by the department for a greatly expanded social service program for New York State mental hospitals.

The student social work aide program is implemented by a special appropriation in the state budget on the recommendation of Gov. Thomas E. Dewey.

Museum in the Making

If a collection of items was good enough to be sought for an antiques show, it was good enough to form the nucleus of a hospital historical collection.

So reasoned the administrative staff of Shadyside Hospital, Pittsburgh. When the collected objects came back from the Penn-Pittsburgh exhibit of antiques they were set up as an exhibit for the hospital's own family and its visitors.

Curious old medicine bottles, including a baby's nursing bottle dated 1835; the original Shadyside nurse's cap, dating back to 1884 when the school was founded following an interview by three staff members with Florence Nightingale in England; a 3 inch medicine kit belonging to the first homeopathic physician in Pennsylvania; the original hospital constitution and by-laws and the first donations and subscriptions book, bearing the imprint of 1866; the first minute book of the Ladies Association in 1869; an ancient iron from the hospital laundry; rare medical pamphlets and old-time surgical instruments were unearthed from the hospital archives or from the collections and attics of hospital patronesses.

Display boards were used to depict the founders and early historical incidents, the pioneer women supporters, the horse and buggy doctor, the ambulance drawn by two fast horses, the luxurious wicker wheel chair in which grandfather convalesced.

With this as a beginning, a full-fledged historical collection will be assembled and will be used for display on special hospital occasions and lent to clubs and civic organizations interested in the institution.

Four Sisters

Shortly before Shadyside was invited to enter its first antiques show, another exhibit was going on in the Pittsburgh home of the four Misses Tebbetts.

The Tebbetts family moved to Pittsburgh from Kentucky when the hospital was small and in another location and has interested itself in the hospital since those early days.

Before World War II the Misses Tebbetts opened their home to the public to display a loan exhibit of needlepoint, the proceeds going to Shadyside.

Recently, the sisters assembled at great expense from far and near a second needlepoint loan exhibit and threw their house open to the interested public for three successive days.

When the third day was over, "the girls" turned over the $535 they took in to the hospital to buy an operating table for the new wing.

Through the Years With—

Before we quit the tree bordered grounds of Shadyside—what a different connotation its name would have if there were no trees about!—we ought to mention that four years of effort on the part of the Nurses' Alumnae Association has brought forth a history of the hospital called "Through the Years With the Nurses at Shadyside Hospital."

Besides recording the history and rich traditions of the hospital and school, the book includes a complete directory of graduate nurses from 1884 to mid-1945. A limited number of autographed copies is available containing the inscriptions of the doctor, the member of the Ladies Association and the graduate nurse oldest in years of service to the hospital.

READER OPINION

Blue Cross

Sirs:

The MODERN HOSPITAL is to be congratulated for its editorial, "Save That Principle!" (June 1946, p. 41). It goes without saying that the easy way out of the present dilemma is to accede to the demands of certain hospital administrators and pay a cash allowance toward room and board.

This is an easy way out for Blue Cross administrators, because it provides a simple and easy way of administration. In some areas there will be no great hardship to the subscribing public under such an operation as long as inflation does not carry the rates for bed and board too far beyond existing levels. If hospitals are forced to meet further demands for increased pay rolls, and no doubt they will be, the only result can be a penalty on the subscribing public. This may well be regarded as a "public be hanged" attitude.

If hospitals, through lean and good years, depend upon public support, financial and otherwise, no such attitude can be accepted without damaging results. Who knows—we may be forced into some such kind of deal, but it never should be attempted except under the most dire circumstances. The minute Blue Cross deviates from its fundamental concepts it should then deserve to lose prestige in the community. The unfortunate part would then be that the hospital, too, will lose its prestige.

I do not understand why hospital administrators and their trustees are not willing to take a broad point of view. I do not understand why plan administrators and their board members are not always willing to recognize conditions, be alert to changes and work at common purposes for the desired end.

R. F. Cahalane
Executive Director
Massachusetts Hospital Service
Boston

500 Year Old Hospital

Sirs:

How would you like running a hospital that is hundreds of years old?

I had the wonderful experience of visiting just such an institution, and it was one of the real pleasures of France for me. The Hôtel Dieu has kept its doors open all these years and is still a most amazing place. I've always connected museums with something not very much alive, and hardly the place I'd choose to be a patient.

But it's as pleasant as you can imagine. The one room that we visited where two tuberculous patients were isolated was equal to any $20 a day number you'll find in the best U. S. hospitals, and the patients reflected their cheery environment. The rotund and pleasant padre who showed us around made the whole place cheerful with his booming "Bon!" to everyone, and he had a wonderful ability to spin yarns with gestures appropriate to complete our understanding of his French.

What wonderful chinaware they had! It had been in use until twelve years ago, when they decided to preserve what was left of it for their museum. The kitchen was something out of this world, with fine large polished steel meat hooks and myriads of fine brass and copper ladles, dishes and other kitchen equipment. On one side was a huge fireplace complete with spit. Of course, a spit in France wouldn't be complete without a "Bertrand"—that's a little figure on the gears which turns as the spit turns.

The pharmacy carried you away to the den of some alchemist with its huge, brightly burnished copper stills that looked like a couple of oversized teapots.

At about this stage of the visit we were reminded that here was made some of the finest Burgundy that comes out of France, and that at the present time it was valued at 2000 francs per liter (that's $40 a bottle), but it seemed that our French was inadequate to prod the padre loose of even a medicinal dose of the golden liquid.

Harry Agress, M.D.
St. Louis

Visitors' Pamphlet

Sirs:

The May issue of the Small Hospital Forum prints an article entitled "They Will Visit the Sick." The pictures appearing with this article in themselves tell the story many of us have been trying to tell our visitors. Perhaps some of the printed material could be deleted and the emphasis placed on the pictures and the story they tell, put up in pamphlet form.

The visitor problem always has been and always will be with us. It strikes me that such an article would do much to educate the public on what is proper with reference to the general conduct of visiting in the hospital.

N. E. Hanshus
Manager
Luther Hospital
Eau Claire, Wis.

SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Detroit Medical Hospital, Detroit, Michigan: Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Me., and others.

"Calling Dr. Jones"

Question: What is the best type of doctors' call system—sound, silent or a combination?—M.G., Okla.

ANSWER: In my opinion the best type is the sound system which should be located in the nursing stations, subdued, and not loud enough to be irritating to patients. Physicians must "check in" at the nursing station on the floor to acquaint the supervisor that they are on the floor. The supervisor, in turn, must cooperate by calling the physician to the telephone if his name is paged.

One may devise a code system, such as "Calling Dr. Jones" for local or house calls; "Calling Dr. Jones, Dr. Robert Jones" for an outside call to let both the nurse and the doctor know whether or not the call should be answered immediately. Emergency calls may be made in the following manner: "Calling Dr. Jones 99."

In my experience the silent system is not efficient.—ROGER W. DE BUSK, M.D.

X-Ray Pictures of OB Patient

Question: Are there any hospitals in which x-ray pictures of obstetric cases are routinely taken?—M.T., Mass.

ANSWER: The obstetrical department of University Hospitals of Cleveland does not make an x-ray examination of the pelvis in all cases. X-ray examination is made only upon the request of the attending physician as manual examination of the pelvis indicates the necessity for further examination by x-ray.—R. H. BISHOP JR., M.D.

Value of Old Records

Question: What would you do with case histories about 15 or 20 years old that contain only admission sheets, nurses' notes and perhaps an O.R. record?—M.F., Fla.

ANSWER: A great deal has been written about the subject of preserving old medical case histories. Many of the older histories, in a majority of hospitals, are valueless from the standpoint of medical education or research. On the other hand, it is always possible that old medical records may be called on for court cases or other purposes.

It would, therefore, seem advisable to keep these old histories. In the event that storage space is not available, they should be microfilmed.—E. W. JONES.

Cost of Blood and Plasma

Question: What should be the charge for whole blood and plasma?—J.S.W., Mass.

ANSWER: In making charges for blood and plasma it is necessary to know the method by which these are obtained and administered and the departments responsible for each part of the procedure. If the laboratory of the hospital conducts a blood bank, then the cost of the conduct of the bank must be the governing principle in determining charges. Materials, technician's and pathologist's time, maintenance of space and equipment and the cost of maintaining an adequate record system must all be included.

If it is necessary to pay donors, this must be included as a cost of preparing the blood or plasma. Since conditions differ in many localities it is not reasonable or financially equitable to fix any standard fee for these services.—NELLIE G. BROWN.

Fixing Laboratory Fees

Question: What is the best system for making laboratory charges?—R.W.C., Ohio.

ANSWER: In my opinion the best method is to charge for each individual test. If the cost accounting is correct, the charge for each test should include the cost of materials, technician's time, pathologist's time, time of the office used in recording and the cost of maintenance of the laboratory.

Unfortunately, such careful cost accounting methods are not customarily considered and the price of each test is an empirical amount which has been arrived at by custom or precept. This accounts for much of the dissatisfaction in many quarters arising from what are believed to be unfair laboratory fees. In instances where time and materials can be saved by conducting two or more tests of different kinds at the same time it seems reasonable to charge somewhat less than would be necessary if the tests were conducted separately.

It is my confirmed belief that the practice of so-called "flat fees" is unsound and unreasonable.—NELLIE G. BROWN.

From Private Room to Ward

Question: If the private patient falls behind on his bill, should he be transferred to the ward? If so, by what procedure?—J.C.M., Ill.

ANSWER: Generally speaking, no. This policy presumes that you have an admitting procedure which carefully explains the costs of your various accommodations and acts as a check upon unwise use by patients of the more expensive accommodations. In the event that it becomes necessary to transfer a private patient to ward accommodations, it should be cleared with the attending physician and the reason for this transfer should be explained to the patient or responsible relative. This certainly is a phase of hospital public relations that is best handled in keeping with the motto "A Stitch in Time Saves Nine."—WILLIAM J. DONNELLY.

Routine Laboratory Work

Question: What routine laboratory work should be done on each patient entering the hospital?—L.S.M., Iowa.

ANSWER: The American College of Surgeons recommends the following routine examinations: (1) urinalysis, chemical and microscopic; (2) blood examination, red, white and differential cell counts and estimation of hemoglobin; (3) blood clotting time in all tonsil and adenoid cases or suspected bleeders; (4) examination of tissues removed at operation; (5) blood test for syphilis.

I would recommend that these examinations be the minimum and that the staff be permitted to suggest other examinations upon admission, where indicated, without penalizing the patient too severely as regards costs.—WILLIAM J. DONNELLY.

Place for Fluorescent Lighting

Question: What do you think of fluorescent lighting for corridors, for patients' rooms, nurses' stations, utility rooms?—K.E.H., Ohio.

ANSWER: By and large fluorescent lighting is ideal for corridors. This type of lighting is particularly effective in any location where the lights have to be on a considerable portion of the day. This is because of the much lower current cost for fluorescent lighting.

The use of fluorescent lighting in patients' rooms is opposed because these rooms should be, insofar as possible, furnished to make them look like high grade, comfortable, cheerful hotel rooms.

Fluorescent lighting is ideal for nurses' stations and utility rooms.—E. W. JONES.

LOOKING FORWARD

Surgical Quality in Hospitals

THE "inoperable" patient is a nightmare to all conscientious hospital executives. Was the patient really inoperable or did the operating surgeon lack the necessary qualifications to deal with the surgical problem which confronted him? How good were his diagnosis and his preoperative judgment in the first place, and his operative skill and postoperative care in the second place?

Why is it that hospital executives trust their own loved ones to none but the surgical best and stand guard over the patient from the moment of his admission throughout his stay? Who knows better than the hospital executive the thousands of possibilities for harm that may befall the patient who, while struggling for life, may have the additional handicap of surgical mediocrity thrust on him?

Nature often condones surgical mistakes and comes to the rescue of the perpetrator even though, of all practitioners of the healing art, responsibility sits heaviest on the surgeon. How shall we seek the best and, having found it, how shall we encourage it against all efforts of a selfish nature to dislodge it in the hospital? They say that an incompetent surgeon cannot survive long in any environment; of all physicians, his productivity is under the closest scrutiny at all times. But technical skill is not enough. "The operation was successful, but the patient died" and "He talks a good operation" are only a few examples of popular reaction to certain staff situations which should be on our minds every moment of the day, if we would not have them on our minds during the night.

The greatest single task of any hospital executive is the prevention of malpractice in his hospital. This is not an easy assignment since it is almost entirely a matter of conscience and administrative statesmanship. The hospital executive who is a layman cannot be excused from such a task and he must therefore learn a way to insist throughout his administrative life on nothing but the best for his patients at all times. The hospital executive will be told that the surgeon, too, has a conscience and must possess surgical statesmanship, but neither the one nor the other may relax his vigilance if we are to make sure of the patient's safety.

The abortionist and the "tonsil snatcher" are flagrant examples that are easily dealt with. The surgeon whose performance is uneven, the fee-splitter who admits his dishonesty and inferiority by the very act of sharing his fee in secret, the sadist and the unproductive—these are exceptions but they must be retired from surgical activity. Much greater damage is done by turning aside from the best through nepotism and other pernicious forms of favoritism.

We must be as careful in selecting surgeons for our patients, and encouraging them wholeheartedly thereafter, as we are in selecting them for ourselves and those who are dear to us. Certification alone and fellowship in the American College of Surgeons are not enough. A diploma is a legal document. There are moral documents which require our close attention.

The Architects Withdraw

APPARENTLY believing that an architect is an architect and special abilities within the profession should not have any official recognition, the American Institute of Architects has repudiated the work of its representatives on the hospital architects' qualifying committee of the American Hospital Association and withdrawn from further participation in this project.

The action is a grave disappointment to the A.H.A.'s Council on Plant Operation and Maintenance and other hospital people who believe that the roster of qualified architects could become a powerful agency for the improvement of hospital design and construction. The A.I.A. has taken what appears to be a backward-looking position in refusing to recognize that the complexities of hospital design demand a thorough knowledge of hospital function. One might just as reasonably advocate abolition of the American Board of Surgery on the grounds that every doctor of medicine has had basic surgical training.

However, the architects do have one legitimate complaint: The A.H.A. released its initial list of qualified hospital architects to the press, thus inviting—or at any rate not discouraging—the use of listing in the solicitation of commissions. The whole idea of the roster was not to get business for certain architects but to get hospitals built by men who know what they're doing. Its use as a lever to take jobs away from unlisted architects should be specifically prohibited, at the penalty of re-

moval from the roster. Releasing the list to the press played right into the hands of the unethical minority. Undoubtedly, the list was released without consideration of this possible result, and any similar error can be avoided in the future.

The decision of the A.I.A., however, remains a discouraging step in the wrong direction. If some of the members who voted against the A.H.A. had only been patients at one of those awful hospitals built by an architect who is a wizard on shoe stores or salmon canneries the result might have been different.

Opportunity to Help

ORGANIZATION by the American Medical Association of a Therapeutic Trials Committee to encourage and assist medical investigators in assessing the usefulness of new drugs is a healthy step toward better coordination of medical effort. The committee should have the support of every hospital and hospital staff.

According to the association's announcement, the new committee will organize impartial clinical trials of biologic and pharmaceutical agents which offer promise in the prevention, treatment or diagnosis of disease, for the purpose of aiding sound research on medicinal agents and promoting therapeutics through understanding of the uses and limitations of drug products. In initiating its program, the committee seeks information and suggestions from hospitals and hospital staffs on their facilities and interests and their competence to conduct clinical trials in the various branches of medicine.

It is only through such voluntary coordinating efforts as this that we can benefit from the results of group effort without sacrificing the advantages of individual action and independent control. Participation in the committee's program to the full extent of its ability to be helpful is thus a major obligation of all hospitals.

Discussion of the Therapeutic Trials Committee and what the hospital can do to aid the program should find a place on the agenda for the next staff meeting at every hospital. Voluntary cooperative projects of this kind in every field of medical interest, with every appropriate person and institution taking full part, offer the best hope for welding America's superb but diffuse medical and hospital facilities into a real system.

Leaps After Looks

THE astronomic demand for hospital facilities all over the country and the impossibility of handling the demand without substantial new hospital construction are reviewed in a report appearing elsewhere in this issue of The Modern Hospital. Yet the report also reveals that many hospital leaders are hesitant about pushing building plans, even in the face of excessive demands apparently resulting from stable as opposed to temporary factors.

Probably this hesitancy reflects in part the fact that hospitals are having a hard time finding enough employes to staff present plants, let alone additions, and in part, too, the uncomfortable feeling that this is a time for watchful conservatism.

Whatever its origins, this restraint is wholesome to the extent that it may prevent hospitals from embarking on building projects simply because the money is at hand or can be obtained and there are patients clamoring at the door. More and more, hospitals are seeking expert help in evaluating the long term need for hospital facilities and integrating their plans with those of other health agencies in the community. With all its discouraging implications, the present report includes hopeful signs that a great weakness of our hospital structure, arising from the tendency for hospitals to be built where somebody has the money to build them instead of where they are really needed, may be avoided in the expansion period that lies ahead.

John R. Mannix

AFTER more than twenty years in the hospital field, John R. Mannix has resigned as director of Chicago's Blue Cross plan and chairman of the national Blue Cross Commission. With Harold Lichty of Detroit, he is entering the hospitalization and medical benefit insurance business in an effort to do, as he expresses it, "the job I hoped Blue Cross could do," *i.e.* to give Americans uniform, comprehensive health insurance protection.

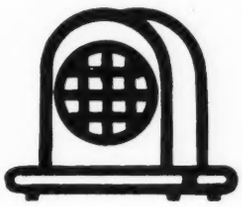
Certainly, there is keen regret among hospital and Blue Cross people at the loss of so able a colleague. Mr. Mannix has been widely recognized as a thoughtful, resourceful, articulate leader. More than most others, he retained the fervent spirit which characterized the early days of Blue Cross.

In addition to this natural regret, there is also an uncomfortable feeling that Blue Cross may now find the going tougher than ever in competition with commercial insurance. This feeling is noticeable chiefly among those who think it is important for the hospital sponsored, nonprofit associations to continue to dominate the hospitalization insurance picture, lest outside groups make their influence felt in setting hospital rates.

Whatever their thoughts in connection with his departure may be, Mr. Mannix' many friends in hospitals and Blue Cross plans all wish him and his associates well in their new venture.

Thought for the Dog Days

A PREPAYMENT plan for veterinary care for dogs is envisioned by the manufacturer of a popular dog food. According to plans now outlined the program calls for voluntary agreements between dog owners and veterinarians. This voluntary feature of the plan ought to win the approval of Dr. Morris Fishbein, comments the Reading, Pa., *Times*, because he "has long been giving the impression that, in his opinion, socialized medicine is something that shouldn't happen to a dog."



The Muted Voice of Medicine

"Quiet, please!" some doctors want the A.M.A. to tell Dr. Fishbein — but can they make it stick?

ROBERT M. CUNNINGHAM JR.

IF delegates at the American Medical Association convention in San Francisco early in July had approved a resolution specifically admonishing Dr. Morris Fishbein to speak no more as the voice of American medicine but confine himself instead to his official duties as editor of the *A.M.A. Journal* and other publications, they would have been legislating against nature. As Dr. Fishbein himself candidly told reporters at San Francisco, no one can make him stop talking.

Actually, the newspapers jumped the gun when they reported that Fishbein had been so repudiated; the resolution was never voted on by the delegates. Instead, the whole matter of Fishbein's loquacity was referred to the association's board of trustees, which, like Jehovah, moves inscrutably its wonders to perform.

Moreover, it would take more than a resolution to break the twenty year habit of the newspaper reading public of accepting Fishbein's utterances as organized medicine's final doctrine. As a matter of fact, it is doubtful that this result could be achieved by any method short of firing him—an expedient which has been urged repeatedly over the years by a small but fervent group within the profession.

This year's more or less public attempt to muffle Fishbein as A.M.A. spokesman is actually a tribute to the persistence of the opposition group, which has come to every convention for the last ten years armed with resolutions demanding Fishbein's scalp. Insiders claim that formation of the Council on Medical Service and Public Relations three years ago was part of a compromise aimed at appeasing the kill-Fishbein forces. If so, the deal was a flop from their standpoint. Instead of silencing him, the council simply gave Fishbein another instrument to play on.

The 1946 effort, which includes the employment of a publicity director for the A.M.A., might possibly end in a similar reversal. Keeping Fishbein quiet by appointing someone else to speak in his place may be compared roughly to putting a Chihuahua's muzzle on a great Dane; it might work until he gets the hang of it.

His mantle as medicine's spokesman was never formally placed on Fishbein's shoulders anyway. It just grew there. Whatever its origin, his status as A.M.A. oracle was given semiofficial recognition once by Senator Claude Pepper of Florida, who asked Fishbein at a hearing in Washington if he wasn't, "so far as the American public is concerned, the man, the official, the agency, through which the policies of the American Medical Association are regularly expressed in writing and in speech." Having labored the point through several questions which Fishbein answered by denying that he was anything more than an editor, Pepper finally won a wearied assent to the larger definition, and it was so written into the record.

Officially or not, Dr. Fishbein is an able and articulate speaker who can give out as the needs of the moment demand with oratorical periods, incisive sarcasm, academic se-

verity, Rabelaisian wit, or any combination of these which may appear to suit either the occasion or his own mood, or both. As many hospital people know, his effectiveness on the platform, in the broadcasting studio or on the witness stand is tremendously enhanced by an agility which keeps him always a jump or two ahead of his hearers; a resonant, if somewhat nasal, voice, and a 200-word-a-minute delivery to which his habitual overemphasis on enunciation lends terrific impact.

Forensically, he is at least an even match for anyone with whom he is likely to cross syllables on medical or medical-economic programs. He is a mobile library of information on public health, the costs of medical care, medical education, mortality rates and the incidence here and abroad of heart failure, cancer, tuberculosis, diabetes and dozens of other diseases.

Statistics on these and similar subjects flow forth from Fishbein in a steady stream whenever a questioner or platform opponent turns on the faucet with an appropriate inquiry or statement. Sometimes Fishbein turns on the faucet himself. In fact, it has been observed frequently that those who debate these matters with Fishbein are more likely to be exhausted by the volume of his expositions than subdued by their logic.

Opponents Deflated

He is adept, too, at change of pace. At an N.B.C. Town Meeting program several years ago, Fishbein had been answering every question from the audience with a five or ten minute oration, when, toward the end of the hour, an earnest, studious looking young man asked a question beginning, "Does the A.M.A. oppose . . ." and continuing with a long-winded, provocative description through which his anti-A.M.A. bias showed plainly. Fishbein, who had been interrupting everybody all evening, heard the question out patiently. Then he stepped to the microphone and said simply, "No."

Whatever his talents, Fishbein has been a public speaker by accident of circumstance. The rostrum is not his natural habitat; originally, he was a journalist. After a public school education in Indianapolis, the home of his immigrant parents, where he became comparatively famous as the boy who knew more than most of his teachers, Fishbein went on to the University of Chicago and Rush Medical College. Following his graduation in 1912, he became research pathologist and attending physician at a Chicago hospital for contagious diseases, a post which he held until the next year, when Dr. George H. Simmons, then editor of the *Journal,* needed an assistant.

Became Editor in 1924

Fishbein, whose adroitness with language had been outstanding in medical school and who had been contributing editorials to the *Journal* to help finance his education, was a natural candidate for the job and was appointed. He became editor on Dr. Simmons' retirement in 1924. Since that time, he has kept his eye on the main chance and made the *Journal* by common consent the leading medical periodical in the world.

For all his speaking, debating, conferring and miscellaneous medical master-minding all over the country, Fishbein has usually been back at A.M.A. headquarters in Chicago Friday and Saturday, getting the *Journal* ready to go to press Monday. He has a sizable staff of assistants, headed by Dr. Edwin P. Jordan, capable associate editor, and including assorted manuscript editors, news editors, foreign editors, make-up editors and men and women who work on the medical specialty journals also published by the A.M.A. and edited by Fishbein. Yet he handles a staggering amount of detail himself—reading scores of manuscripts every week and editing a number of them personally; writing editorials for the *Journal* and for *Hygeia,* monthly A.M.A. publication devoted to telling the public the discouraging truth about its bodily frailties; writing a daily health column for the *Chicago Times* syndicate and at least one book a year on health or medical subjects, and attending to a huge personal correspondence.

A large part of Fishbein's success with the *Journal* is attributable to his insistence on keeping it up to date. For a scientific periodical it is remarkably current, bristling every week with up-to-the-minute news of medicine from all over the world. Tearing an issue apart to make room for late copy is routine procedure. "Fishbein thinks this is a daily!" tired assistants have been heard to grumble as they start making up the *Journal* for the third or fourth time in a single week.

These eleventh hour crises contribute to the atmosphere of genial confusion which generally prevails in the editor's office. Secretaries, editors, copy boys and callers come and go freely; Fishbein interrupts himself or his visitors constantly to give instructions or answer questions, sometimes keeping two or three conversations going simultaneously in the office and answering the telephone, which rings all the time, himself. Anyone who calls the A.M.A. and asks for Dr. Fishbein talks to him if he's in the building. His protection against inroads on his time by cranks is simple: he hangs up.

Sometimes He Listens

Fishbein's conversational manner is a modified version of his platform personality. He is likely to monopolize the discussion, talking loudly and rapidly, gesticulating, exercising his eyebrows and not sparing the first person pronoun. He is medium short, and he bulges noticeably today at 57. Under a shining bald head, his long, dark-skinned face is in constant motion when he talks, keeping pace with his characteristic exaggerated inflections and lapsing into an expression of sharp inquisitiveness whenever, as happens occasionally, he is listening.

Fishbein's conversation is liberally punctuated with references to his accomplishments and acquaintanceships, with emphasis on celebrities, and his limitless self confidence nourishes a radiant optimism concerning everything he has anything to do with.

When, during a printers' strike in Chicago a year ago, the *Journal* missed its first issue in more than sixty years of publication and the aroused strikers looked good to stay out for weeks, Fishbein was the only man at the A.M.A., and one of the few in the city having anything to do with publishing, who wasn't greatly disturbed.

While everybody else stood around in corridors or sat in offices speculating and dissecting the latest communiqués from the strike front, Fishbein went right on working, just as though *Journals* were rolling off the presses. "They'll be back in a day or two," he declared cheerfully when anyone asked him how long he thought the printers would stay away. He kept on saying this for weeks, as the strike dragged on, and it probably hasn't occurred to him yet that he was wrong.

Like that of most prolific writers, Fishbein's own prose is spotty. When it falls below par either in clarity of thought or in style, the cause is likely to be haste-producing pressure built up by a threatening deadline. Given plenty of time, Fishbein occasionally turns out copy which marches from fact to fact or from premise to conclusion in simple, lucid and sometimes eloquent sentences.

He rarely falls into the common error of scientific writers and editors who make a fetish of technical detail—often at the expense of clearness in thought or emphasis. Especially in his popular books and newspaper columns, his chief concern is getting the big idea across. He may veto a technical revision suggested for a *Hygeia* article, for example, if he thinks the correction will throw the lay reader off the pace. His reward is usually an anguished cry of "Oversimplification!" from scientific purists.

A Devotee of Simplicity

From the standpoint of literary style Fishbein is a devotee of simplicity. Frequently this gives his writing the didactic tone which is such an irritating feature of the articles doctors write for laymen. Unlike many writing doctors, however, Fishbein has a horror of literary affectation. "Whenever a writer feels an impulse to perpetrate a piece of exceptionally fine literature, he should obey it," Fishbein says archly in a book on medical writing which is a bible for A.M.A. editors, "but he should then delete what he has written before sending the manuscript to press."

Fishbein also abhors the medical *patois* which so many doctors affect in writing as well as in conversation. For example, he sees red whenever a doctor says that he "operated a patient"—a common solecism in medical jargon which Fishbein says likens surgical patients to elevators and steam shovels. Too, he deplores the tendency of physicians to use adjectives for nouns, as when they refer to a person with heart disease as a "cardiac." Use of the phrase "acute abdomen" to describe an acute condition in the abdomen gives Fishbein an acute condition in the abdomen.

Speaking his mind freely and forcibly all the time, at least until the putative rebuke in July, Fishbein has always kept his enemies burning with zeal. Those who dislike him divide generally into two groups: medical liberals and others who for one reason or another think private practice is outmoded and want a medical new deal, and doctors who think that medicine, like good little children, should be seen and not heard, or who think that Fishbein's flamboyant public character is not a credit to his dignified profession, or who can forget everything except his manners, which are sometimes bad.

From time to time the more enthusiastic members of these diverse groups have banded together in an effort to unseat him. Their consistent failure to be anything more than annoying and, more recently, perhaps restricting, is attributed by some observers to their diffuse origins and interests, and by others to the fact that a solid majority of the medical profession, understanding all his faults, still believes that Fishbein put American medicine and the A.M.A. on the map and keeps them there.

Friction between Fishbein and these various groups is frequent and corrosive. Medical progressives think of him as a symbol of hated A.M.A. conservatism. Doctors who resent Fishbein may owe their feeling to the fact that he is a successful physician who never opens an abdomen or slaps a newborn baby's rear, but those who condemn him as a publicity seeker are only partly right. The main reason Fishbein is constantly in the newspapers is that he knows what the papers want and gives it to them. From the newspaperman's standpoint this is a refreshing quality; most doctors are not exactly communicative with the press.

When a Milwaukee school teacher recently threw away her crutches and walked, after years of paralysis, because, she said, Jesus came to her in a vision and told her to, the papers called on Fishbein for a statement. Experience has taught them that there isn't much use asking other doctors to comment on such cases.

"I don't believe in medical miracles," Fishbein told reporters on this occasion. "I believe in science." He went on with a few brisk, quotable remarks on the subject of hysteria and miracle cures generally. Similarly, when blood tests were introduced as evidence during the Charlie Chaplin paternity trial, Fishbein gave the press a brief, instructive lecture on the nature and reliability of such tests.

Plainly, there are two possible interpretations of this policy of giving the papers what they want: either Fishbein is using these occasions as vehicles for personal publicity and aggrandizement, or he sees them as opportunities to present important medical information to the public in a way that will be remembered. Or both.

In addition to reporters, many lay people who work with physicians respect Fishbein for his refusal to go along with the professional cliché which holds that a medical degree is always a badge of intelligence and nobility. Unlike most doctors, Fishbein readily admits that some physicians are stupid and some are venal. Moreover, he recognizes that a layman may have brains and ability—a fact to which an astonishingly large number of doctors are blind.

Not Solely a King-Maker

Fishbein's enemies, however, have generally been more vocal than his friends. For example, a young man in the social science department of Harvard University a few years ago wrote a book called "The Political History of the American Medical Association," an exercise which developed the thesis that Dr. Fishbein was either the leader or the agent of an inner ring of medical politicians perpetually engaged in a gigantic plot to control the association and, through it, the entire medical-hospital field. The truth is probably less sin-

ister than this. The fact that he remains in office in spite of continued powerful opposition is evidence that Fishbein doesn't let his political fences get rusty. It seems unlikely, however, that his preoccupation with A.M.A. king-making is total.

The seeming abandon with which he makes enemies would indicate that Fishbein is not a man to brood about being misunderstood or disliked. He has tangled briefly and buoyantly with, among others, the *Chicago Tribune* and Henry J. Kaiser, the shipbuilder turned automaker. The *Tribune* tilt was confined to an exchange of hot editorials variously interpreting the significance of an outbreak of jaundice in army camps a few summers ago.

The battle with Kaiser, on the other hand, was joined face to face on the floor of the hearings before a senatorial committee investigating the wartime manpower problem. Their bald heads gleaming, the two witnesses traded sharp rejoinders about the "essentiality" of the doctors who were taking care of workers in the Kaiser shipyard at the time. News pictures of the clash featured Fishbein cutting the air with his horn-rimmed glasses, which he uses characteristically as a baton, and obviously enjoying the hostilities, which were giving full play to his contentious talents. Most observers felt that the combatants, who have since become friends, were evenly matched, though a careful study of the transcript gave Fishbein a definite edge grammatically, if not logically.

Occasionally, though, there are indications that Fishbein is not wholly insensitive to criticism. A few years ago, a disgruntled doctor whose contribution for the *Journal* he had rejected with the conventional editorial euphemism about "requirements on our space" jumped on Fishbein by return mail for continuing to print "Dr. Pepys' Diary" in valuable *Journal* space. Hurt, Fishbein was at pains to tell about the incident in the "Diary," a weekly log of his personal travels, troubles and thoughts, which appears in the back pages of the *Journal*. Reader surveys had frequently verified the popularity of this feature, he explained. Apparently, the peevish doctor got under his skin in a way that his more formidable critics have consistently failed to do.

The most dispassionate criticism of Fishbein is that his voice, which was effective for years, has outlived its usefulness, at least for interpreting the economic aspects of medical care to the public. Rightly or wrongly, he is inextricably identified with resistance to any change in medicine, and the need for change to keep up with medicine's growing scientific and economic complexity is now recognized by nearly everyone who can read.

Belatedly, the A.M.A. is clutching prepayment plans to its bosom and crying to the world that this is its very own child. With a new cast the act might go over, but too many people remember Fishbein as the man who wanted to throttle the baby when it was born. Unquestionably, this is the reasoning of many who think the time has come for muting the familiar, brassy tones in the voice of medicine.

In a way, however, it will be too bad if this has to be done, because Fishbein has always been the star of the show, and the box office is sure to suffer if he moves offstage.

A PRACTITIONER had referred a patient with an obscure stomach ailment to a prominent gastroenterologist. He was thereupon given the routine "works" and, at the end, was told by the professor that it was nothing serious—only a nervous stomach. "Aha!" said the patient, "now I can collect on my insurance. Please let me have a certificate for my insurance company."

The doctor declined to give him such a certificate on the ground that the condition was of no importance and would pass with a little therapeutic cooperation. The patient, however, insisted that he had been paying premiums for many years and that he was not going to be cheated out of his benefits now that the great moment had arrived. The argument waxed warm and the professor, who was pressed for time, decided to return the patient to his doctor with the advice that he take the matter up with him.

Later the doctor received this letter: "My dear professor: You will recall my visit to your office three weeks ago when I was referred to you by Dr. Jones for a stomach ailment. You gave me a thorough examination and told me that I had a nervous stomach, but declined to let me have a certificate which I could use to collect disability insurance. After considerable argument you lost patience with me and sent me back to my doctor, who also refused to let me have such a certificate. I now ask you again please to send me such a certificate by return mail. Signed . . . ."

"P.S. It's things like this that make me nervous."

(From a letter to the Hospital Administrator's Correspondence Club by *E. M. Bluestone, M.D.*)

The Hospital Jam Is Here to Stay

Administrators in 18 cities report serious overcrowding but see no chance for relief until hospital construction is speeded up

FROM one end of this country to the other, hospitals are loaded to the eaves:

In Washington, a hospital built for 240 beds had as many as 365 patients one day last month.

In St. Louis, a doctor was unable to find any bed for a patient with perforated ulcer. The patient died.

In Cleveland, some hospitals were discharging obstetrical patients in three days.

In Baltimore, certain types of nonemergency cases were waiting as long as four months to get hospital beds.

In Chicago, one hospital was turning away 50 emergency cases a month and had a waiting list of more than 400 nonemergency patients.

Congestion a Fire Hazard

Everywhere extra beds or cots are crowded into wards and private rooms. Sun rooms, corridors and service areas have been converted into wards; in one city the fire department threatened to close a hospital unless unsafe congestion could be relieved at once.

Admissions are strictly on a priority basis according to the urgency of the case or, in too many instances, the importance of the doctor or patient.

Along with the soaring demand for service, hospitals are still facing help shortages. Nursing staffs, especially, remain depleted as many graduates returning from the army and navy stay away from hospital jobs.

With patients clamoring for admission, some hospitals are even closing floors for lack of help.

In Winchester, Ind., the 35 bed Randolph County Hospital moved all its patients home or to neighboring communities for an enforced vacation. There weren't enough employes left to run the hospital, it was explained.

How serious, actually, is the overcrowding of hospitals across the country? What are the causes of crowding? What are the best ways of meeting the emergency situation? What is the outlook for relief?

To find the answers to these questions, The MODERN HOSPITAL recently asked hospital authorities in 18 of the nation's cities to survey hospital facilities in their areas, then give their best judgment as to the causes and suggested remedies.

Every city reports the same acute shortage of beds: In Boston, the average occupancy of seven large hospitals is 88 per cent of capacity; as it does elsewhere, "capacity" there includes numerous beds spotted around in space planned for other purposes. At a recent meeting of a St. Louis medical society committee appointed to discuss the bed shortage with hospital officials there, one doctor declared that people were "dying every day for lack of hospital beds." The administrator of a Washington, D. C., hospital reported that beds scarcely have time to cool off between patients. Facilities for Negro patients in Washington were described as "shockingly inadequate."

From New York, Philadelphia, Detroit, Los Angeles, San Francisco, Pittsburgh and other metropolitan centers came similar reports describing local conditions as "crowded," "serious" or "critical."

Chief Causes Listed

In the judgment of hospital authorities in 16 of the largest cities in the U. S., the chief causes for hospital crowding are:

1. Constantly increasing public awareness of the value of hospital care in the treatment of illness and injury.
2. Increased population.
3. Lack of substantial hospital construction throughout the depression and war years.
4. Blue Cross and other forms of hospitalization insurance.
5. Scientific advances making hospitalization necessary for diagnosis and treatment of many conditions formerly cared for in homes.
6. High wages and general prosperity removing the financial brake on hospitalization.
7. Housing shortage making home care of illness difficult and unsatisfactory.

8. Heavy demand for elective surgery postponed during war years because doctors were away or patients were too busy.

9. Doctors too busy to make home calls bringing more patients to hospital than ever before.

10. Encouragement of hospitalization by government agencies, notably E.M.I.C.

11. Increased birth rate.

12. Stresses of war years resulting in general breakdowns with cardiac involvement.

When these causes are examined, little hope for early relief from overcrowding appears. Temporary population shifts may ease the pressure here and there, but the factor of more people seeking hospital care more often for more conditions will get worse instead of better unless a critical depression raises high the financial barriers which kept hospital beds empty in the early thirties. Even then, millions will hold onto the protection afforded by Blue Cross and other insurance. It is unlikely that another depression would hit hospitals as hard as the last one did.

In the opinion of most observers, the solution to the bed shortage must be built of steel and stone.

Construction the Only Answer?

Construction of additional hospital facilities is the only way out that hospital leaders can see. While many expansion projects are already under way and the volume of planned construction is huge, completion of enough additions and new plants to relieve the bed shortage materially is thought to be at least two years off. With building regulations, labor trouble and scarcities of construction materials all still to be reckoned with, many experts will not even guess how soon the building program may put needed beds into use.

Furthermore, not all hospital people feel that new construction alone will solve the problem or that rapid expansion of hospital facilities now is wise. "There is a great deal more involved in our problem than simply the addition of more beds," said E. E. Salisbury, executive director of the Chicago Hospital Council.

"I am concerned, in listening to the ambitious programs for expansion which are contemplated, with the apparent small regard for staffing the proposed additions. There are still some hospitals in Chicago which have as much as whole floors shut off owing to shortage of personnel, primarily nurses. Until or unless we are assured of an increase of institutional nurses, it is rather shortsighted to enlarge existing facilities."

The personnel shortage is generally recognized as a complicating factor in the hospital jam. "Even if bed capacities and other facilities are enlarged," said Isabel Baird of Massachusetts Hospital Service, "without the necessary personnel to give the service, the improvement of standards and general progress of hospitals will remain a serious problem."

One or two reports sounded a note of caution on building expansion plans. "I have a feeling that the demand is abnormal at the present time," Joseph G. Norby, administrator of Milwaukee's Columbia Hospital, warned. "My recollections of the period that followed World War I are that conditions were somewhat similar. Demand was generally beyond the capacity of the hospitals." However, Mr. Norby acknowledged, "Milwaukee does have too few beds and our troubles will not be over until there are additional accommodations in the city."

Similarly: "It is our feeling that conditions producing today's heavy demand for hospital beds are only temporary," said Abraham Oseroff of Pittsburgh, "and there is no need for substantial additions to our hospitals."

In another city where one new hospital and several additions are already under construction, it was predicted that the situation would be normal within two years and that unless the city's population continued to increase rapidly there would be a surplus of general hospital beds by 1950.

Growing medical recognition of "early ambulation" in the hospital care of surgical patients is also mentioned among the reasons hospitals should not rush headlong into building projects. If patients actually thrive on hospital routines which get them out of bed the second or third day after major surgery and home in six or eight instead of ten to fourteen days, it is pointed out, the need for beds will diminish as use of this method becomes more widespread, and today's estimates of needs are no good.

Meanwhile, doctors and patients all over the country are scrambling for beds, and worried administrators are trying to set up fair, practical priority systems and make them work. In most cases order of admission is established according to the urgency of the symptoms as assessed by the attending physician. Some hospitals have staff committees reviewing records to make sure that no admissions are gained under the guise of emergency for patients who could easily be kept at home to wait their turn.

Where no question of medical emergency exists, patients are placed on waiting lists, some in simple chronological order, others by rotation among staff departments or members, or both. Even within these lists, however, a great deal of juggling usually goes on, since some patients obviously are in greater need than others and, unhappily, some doctors have more influence than others. So do some patients; plain Mr. Jones may stay home and suffer with his stomach ulcer while Mayor Brown gets hospital treatment for a bad cold.

Tonsils Will Stay Put

Moreover, administrators report that a few doctors try to keep rooms reserved all the time in the name of one patient or another, then switch reservations according to their own needs. In most hospitals elective surgery cases go to the foot of the list. Last week, one Chicago hospital was displaying a large sign on the front door: "No Appointments Being Made for Tonsils and Adenoids."

Fortunately for the 25,000 Americans who seek admission to voluntary hospitals every day, hospital people show no signs of panic, or even alarm, as they survey their jam-packed halls. The situation is grave, but they are used to grave situations. Most of them believe they can squeak by—through rationing beds, cutting down on patient stays and using outpatient facilities wherever possible—until: (1) the personnel shortage becomes less acute and they are able to provide better care for today's huge patient loads, (2) the peak demand for hospital facilities levels off and (3) the construction program swings into full speed and produces more beds.

As yet, nobody has suggested seriously that hospital public education go into reverse and urge people to stay home.

Designed for PREMATURE LIVING

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Baltimore

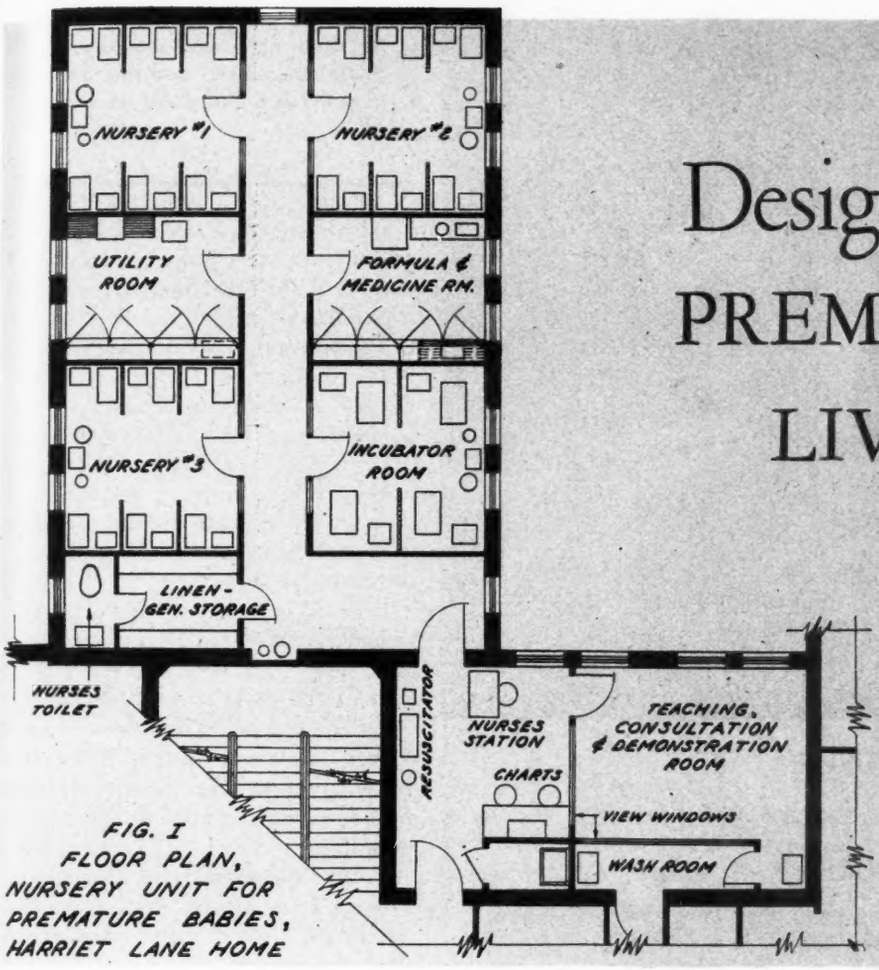


FIG. I
FLOOR PLAN, NURSERY UNIT FOR PREMATURE BABIES, HARRIET LANE HOME

IT HAS long been recognized that special care based upon the physiological needs of premature babies is necessary if the infant mortality rate is to be further appreciably decreased. With these needs in mind a special nursery unit designed exclusively for premature and immature babies has been opened at the Harriet Lane Home of Johns Hopkins Hospital, Baltimore. The unit was constructed as an addition to the Harriet Lane Home at a cost of approximately $100,000. Of this sum, $40,600 was contributed by the government upon the recommendation of the U. S. Children's Bureau under the provisions of the Lanham Act. The rest was made up by private contribution.

Transportation to Unit for Premature Babies: As the unit was designed to care for babies born outside Johns Hopkins Hospital, in the city of Baltimore and the surrounding counties of Maryland, the Baltimore City Health Department and the Maryland State Health Department have arranged for transportation of the baby from the place of birth to the Harriet Lane nursery. The baby is carried in a portable incubator equipped with oxygen by a public health nurse who is prepared to give any emergency treatment.

Nursery Unit: The unit was designed to conform with the standards recommended for nurseries by the Children's Bureau.[1, 2] It is housed on one floor of a wing attached to the Harriet Lane Home but is entirely separated from the other wards of the hospital. It has a capacity of 22 beds, the total floor space is 1457 square feet and there are 16,027 cubic feet of air space.

The unit consists of four nurseries and two utility rooms opening upon a central corridor, a nurses' station, demonstration room and anteroom (Fig. 1). Each of the four nurseries is subdivided by means of glazed partitions into cubicles. Each cubicle contains equipment for one baby. Three of the four nurseries contain six cubicles; the fourth nursery contains four larger cubicles and is used as an incubator and admission nursery (Fig. 3).

Walls, Ceilings, Floors and Lighting: The walls, with rounded corners, are finished in a smooth washable paint. The ceilings have acoustical treatment in order to minimize noise. Floors of the four nurseries and the utility rooms are covered with heavy inlaid linoleum, while those of the rest of the unit are tiled. Two large windows and central indirect lighting fixtures provide adequate illumination for each nursery; in addition, each is provided with a goose neck standard lamp should direct lighting be desired.

Control of Atmospheric Conditions: The entire unit is equipped with the ducts necessary to ensure proper year round control of temperature and humidity by means of air conditioning. No air sterilization

[1]Standards and recommendations for Hospital Care of Newborn Infants, Full-Term and Premature. Bureau Publication 292, U. S. Department of Labor, Children's Bureau, 1943.
[2]Standard Plans for Nurseries for Newborn, in Hospitals of 50 to 200 Beds. Ethel C. Dunham, M.D.; Marshall Shaffer; Neil F. MacDonald, Hospitals, April 1943.

FIGURE 2

Figure 2. A corner of one of the six bed nurseries, showing cubicle, bassinet, bedside table and nurse working with an infant.

FIGURE 3

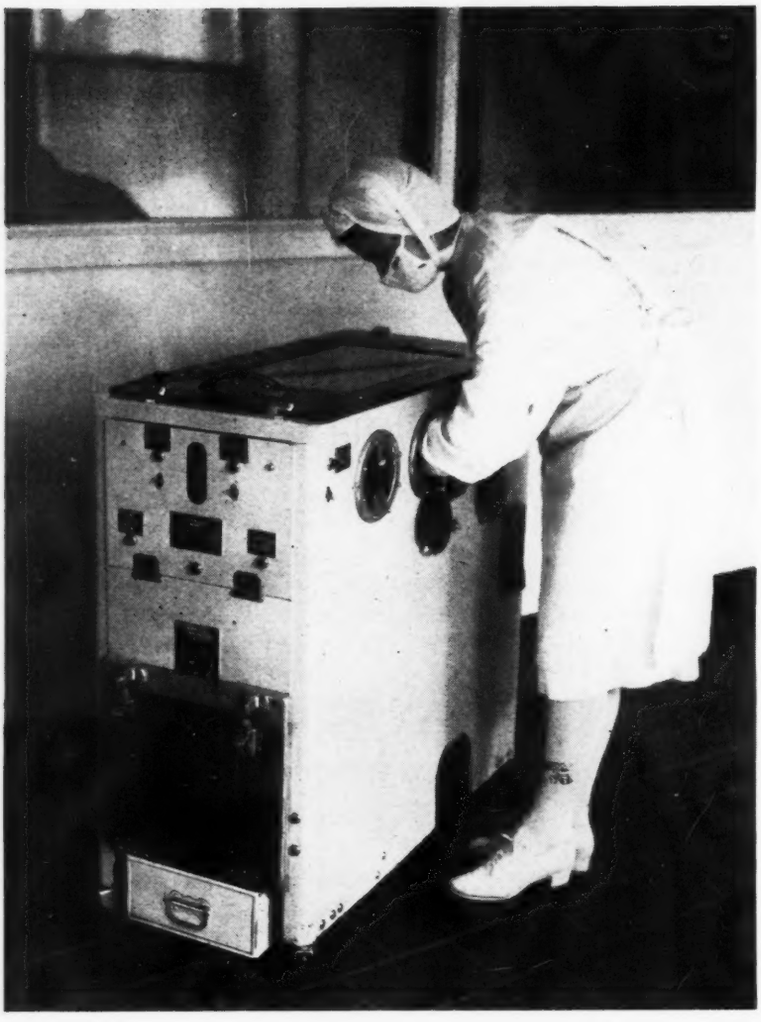


Figure 3. A cubicle in the incubator nursery. The incubator has humidity and temperature control, oxygen, suction apparatus.

methods are employed at present. In order that very tiny infants may have a more meticulously controlled environment incubators are provided.

Furnishings and Equipment: Each nursery contains a central lavatory for handwashing, a linen hamper and a diaper can with lid controlled by foot pedal. Each cubicle (Fig. 2) contains a bassinet or incubator, a bedside table, a chair and isolation gown. The bassinet consists of a pipe metal stand with a steel band basket. The unit is equipped with eight incubators with the conventional equipment (Fig. 3) and one special incubator (Fig. 4) to be used for the smaller infants. The bedside table serves as a work table and contains a twenty-four hour supply of linen and equipment needed for care of the infant.

Additional nursery equipment consists of four suction machines (Fig. 3), an unlimited supply of oxygen and, for the admission station, one resuscitator. The resuscitator consists of a heated crib, to which is attached a small suction pump, and apparatus which permits of the delivery of oxygen under intermittent positive pressure or in a continuous stream as desired. This unit is situated in the nurses' station.

Accessory Rooms: The nurses' station and chart room is so situated that it controls all traffic to and from the nurseries. There is a large viewing window between this room and the demonstration room, beyond which is the anteroom where gowns, caps and masks are donned and hands are washed before entry to the nursery unit (Fig. 1).

The demonstration room is used for parent teaching and nursing demonstrations. Between it and the anteroom is a large window through which parents may see their babies. The nurses' work space consists of a linen room, a general equipment

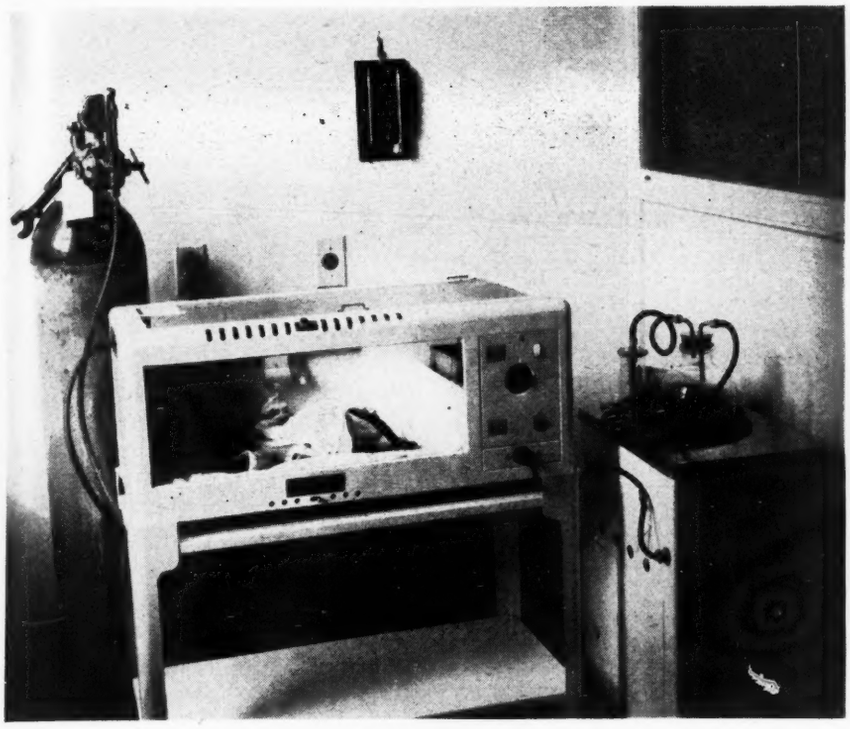


FIGURE 4

Figure 4. This unit provides ultraviolet light for filtering the air; temperature and humidity controls; emergency oxygen, and ports through which the nurse can work on the baby without opening the incubator.

room and a formula and medicine room. The last contains a large refrigerator for storage of formulas and bottle warmers.

Linen is autoclaved outside the nursery as are the rest of the sterile supplies. Formulas are prepared and sterilized in the Harriet Lane milk laboratory and are delivered once every twenty-four hours to the unit. There are no treatment room and no examining room. Treatments and examinations are done at the bedside under isolation conditions.

Technic of Care: The infant is placed in the resuscitator upon admission. There, a brief examination is done by the pediatrician, the eyes are "Creded" and any necessary emergency treatment is given. The infant is then assigned to an incubator or bassinet depending upon his size and condition. Once he is able to maintain his body temperature satisfactorily, he is moved from the incubator to a bassinet in a room kept at a temperature of 80° F. and a relative humidity of from 40 to 50 per cent.

About ten days before discharge the infant is moved to the so-called "conditioning nursery" which is one of the three larger nurseries that has been set aside for the purpose of preparing babies for discharge by exposing them to temperature and humidity conditions more like those they will find in their own homes. During these ten days the baby is taken periodically to the demonstration room so that his parents may receive practical teaching in feeding and bathing him.

Each baby and his equipment are regarded as an individual unit and rigid isolation technic is used by the nurses and physicians in handling the infants. The nurses and ward maid do not work elsewhere in the hospital. No one other than the personnel responsible for the care of the babies is allowed admission. Nasopharyngeal and throat cultures of the personnel are taken at weekly intervals in order that carriers of disease organisms may be excluded.

Nursing Service and Education: At least six hours of nursing care per baby per diem will be given, as recommended by the Children's Bureau. It is planned that the unit shall be staffed by a teaching supervisor, a head nurse, an assistant head nurse and general staff nurses. Postgraduate students will be admitted for a supplementary course of three months' duration and a group of Johns Hopkins Hospital undergraduate students will be assigned for from two to three weeks as part of its general pediatric study. An advanced postgraduate course is being planned on a collegiate level.

Medical Personnel: The medical personnel consists of one assistant resident and one intern from the Harriet Lane Home house staff assigned on rotation for three months and two months, respectively. These pediatricians work under the direction of a member of the Harriet Lane Home staff assigned part time to the newborn service.

Administrative Capsules

● He who searches for the line of demarcation between the "acute" patient and the "chronic" patient is doomed to fail—it is only a question of time!

● When the psalmist wrote "Cast me not off in the time of my old age; forsake me not when my strength faileth" he showed a profound understanding of human nature and, though his eyes were lifted to heaven, he made his appeal to the sons of men which would ring in their ears through the ages.

● Anyone who professes an interest in the long term patient must agree that the comfort and the survival of this type of patient become more certain as he is brought closer and closer to the source of all knowledge in the field of medical science. The landscape is a good therapeutic agent, but it cannot replace the services of a qualified physician.

E. M. Bluestone, M.D.

Polio Calls for *General* Care

JOSEPH G. MOLNER, M.D.

Deputy Commissioner and Medical Director, Detroit Department of Health
Medical Consultant, National Foundation for Infantile Paralysis

ONE of the important problems encountered in the organization of local facilities for the care of infantile paralysis is the lack of available hospital beds. The only adequate care of the person afflicted with poliomyelitis is hospital care.

For the past half century or more, it has been considered good practice to develop special hospitals for the care of communicable disease patients. Strict segregation of such persons appeared to be the only means of rendering proper care.

In recent years, this trend has changed. There is developing gradually among medical and public health workers the attitude that communicable diseases can be cared for in general hospitals. This does not imply that cases should be admitted to any service nor does it imply that they can be cared for without the use of proper isolation precautions and the observance of a proper communicable disease technic.

Quarantine Procedures Changed

Concurrently with this change in attitude in the admission of communicable disease patients to general hospitals has come a change in the attitude toward the value of quarantine procedures. Several states have changed their communicable disease rules and regulations and quarantine is not required. Here again, the change does not in any way imply that proper precautions should not be taken to avoid the spread of the disease to other persons. The isolation of the patient is still considered good practice but the restriction of the complete household is looked upon as unnecessary.

If facilities are available in a locality in which poliomyelitis patients or other communicable disease cases can be hospitalized as a group, such

group hospitalization, either in wards or in private rooms, lends efficiency to the management of the patients and the operation of such units. In many sections of the country special facilities are not available and the building of communicable disease hospitals is contraindicated from an economic point of view.

Certainly in sparsely settled areas where the population is small and contact among persons is relatively infrequent, the incidence of communicable diseases is usually low. Communicable disease case loads fluctuate with the seasons of the year and also with cyclic epidemic periods. It is conceivable that even if the standards for communicable disease beds were met, there would be occasions during which the facilities would be inadequate.

The American Hospital Association recommends that there be approximately one communicable disease bed available for each 2000 population. The estimated need for hospital beds for the care of persons with general illnesses is four or five beds for each thousand.

Actually, these standards are complied with in few sections of the country. Larger cities and more heavily populated areas may approach these standards. However, it is conceivable that even if communicable disease hospital beds were available according to these standards, they would be utilized only during certain seasons of the year because of the definite fluctuation of communicable disease case loads, and it is also conceivable that during acute outbreaks of poliomyelitis and other communicable diseases these beds would not be sufficient.

The exact method of transmission of poliomyelitis is still unknown. Some evidence is available to lend support to the person to person route of transmission, but there is also evidence that tends to minimize the significance of this theory. Certainly, it is a known fact that the secondary attack rate of poliomyelitis is virtually negligible. Secondary cases in households in which there are other potentially susceptible persons are the unusual rather than the usual occurrence.

Virus Distributed Widely

Too, it is unusual to see a doctor, a nurse or other person charged with the care of poliomyelitis cases succumb to the disease after exposure and a reasonable incubation period. The virus of poliomyelitis during epidemic periods is widely distributed among the exposed population. This distribution of the virus is so general that it would appear that the protective measures used in the past are feeble attempts at "closing the barn door after the horse has been stolen."

These many factors are supporting evidence for a change in attitude toward the hospitalization of poliomyelitis cases in general hospitals. Certainly, from an economic point of view, special hospital facilities are admittedly expensive and inefficient because of the cyclic nature of the disease. From an epidemiological and scientific point of view the disease apparently is not readily transmissible from person to person and, in brief, the risk to exposed persons is negligible. It must be emphasized,

however, that this new principle proposed does not recommend the condoning of poor hospital technic.

The shortage of personnel in hospitals has been a major problem in recent years; the shortage of professional personnel has been particularly acute. It is noteworthy that the modern methods of poliomyelitis therapy require many more man hours of time than do the older therapeutic measures. To meet this demand volunteers are being extensively used. Mothers, fathers, aunts, uncles, neighbors, friends and other interested persons are offering help. These people in many sections of the United States are being trained under the National Foundation for Infantile Paralysis' poliomyelitis emergency volunteer program to become more efficient. It is hardly in keeping with sound reasoning to exaggerate the communicability of a disease by precautionary measures on one hand and to solicit lay assistance on the other. Hospital administrators appreciate the need for this assistance and the medical profession realizes the relatively low secondary attack rate of poliomyelitis; these two thoughts must be carefully coordinated and significantly called to the attention of the unknowing public and even the skeptics of the medical profession and hospital administrators.

No scientific evidence justifies the dread and fear of poliomyelitis as a highly communicable disease. Hospital administrators, doctors, nurses and the layman must sooner or later appreciate this fact. Better management and care of the person afflicted with infantile paralyisis are dependent on intelligent understanding of the situation. The admission of poliomyelitis patients to general hospitals will alleviate the greatest problem in the care of persons afflicted with this disease.

Pension Plans Are Up to Date

Are You?

HOMER WICKENDEN

Secretary
National Health and Welfare Retirement Association, Inc.
New York City

NO HOSPITAL trustee or administrator likes to feel that he is behind the times. His sole purpose is to give the sick the best of care and usually he prides himself on the up-to-dateness of the service his institution provides. But in one respect nearly all hospitals are out of date, that is, in the provision of some form of security for their own employes.

Hospitals Were Excluded

Social security was established by Congress in 1935 and set in operation in 1937, but hospitals and other nonprofit institutions did not take a positive attitude toward being included under its provisions and they were excluded. Today, workers in industry have social security and the benefit of private pension plans in addition. But hospitals offer almost nothing in this field.

As a result hospitals are having a desperate time obtaining well qualified workers. Nurses returning from the armed forces prefer to work for the government or in industry where they have pension rights rather than return to their usual hospital positions. The average nonprofessional young employe is choosing industry in preference to hospital work for the same reason.

Why does an employe leave the hospital for industry? In part, it is the wage scale; in part, the working conditions. Whether he says much about it or not, the employe's mind often dwells on the numerous hazards of life.

What will he do in case of serious illness, unemployment, death and old age? If he can achieve security against these hazards by deserting the hospital for industry who can criticize him for his choice?

A statement that has strong implications for hospitals in their personnel relations was recently issued by Dr. J. Douglas Brown, director of the industrial relations section of Princeton University and chairman of the labor market research division of the Social Science Research Council. He declared that the great cause of bitterness in labor relations today is not wages as such but the sense of insecurity felt by workers as human beings.

Basic Causes of Conflict

Collective bargaining over wages has been widely accepted. However, Dr. Brown added, such problems as sickness benefits, medical care, pension plans and dismissal payments remain fundamental causes of rancor in bargaining negotiations despite the government's social security program.

While hospitals generally provide sickness benefits, through the Blue Cross or otherwise, few have given their employes security against old age and death.

In considering the establishment of a program to meet these hazards, several questions will arise in the minds of a hospital trustee or administrator. (1) Will social security be amended to cover hospital workers? (2) What should a hospital try to provide in the way of benefits? (3) What will the cost be? (4) Can a hospital afford to inaugurate such a program?

1. The latest word from Washington is that amendments to social security to cover hospital workers will not be enacted for many months. This is only one question among many relating to social security that will require extended study before action is taken.

Even if such action is taken it should be borne in mind that industry has found it advisable to supplement social security because the benefits are intended to be only at a subsistence level. At present the average monthly payment to a primary beneficiary under Old Age and Survivors' Insurance is about $24 a month.

2. Many hospitals provide medical care for their employes at reduced cost, frequently through Blue Cross participation. A small number of hospitals provides group life insurance; an even smaller number has a pension program worked out on a sound basis. Few hospitals are covered by unemployment insurance because they provide steady employment. The problem for hospitals is primarily one of providing death benefits and retirement income.

Types of Plan Differ

In providing these coverages, however, the question is, what kind of a plan shall be used? In this field the needs of a hospital are different from those of industry and it is the recommendation of the pension committee of the American Hospital Association that a plan differing in several respects from those followed in industry should be used. An up to date philosophy regarding vested rights is important.

It is the opinion of the pension committee that the employe's sense of security grows out of the pension rights he acquires. And if it is the purpose of the pension plan to provide this sense of security the employe should not be forced to wait ten or fifteen years to have a claim on benefits created by the contributions of the hospital. It is the immediate vesting of these rights that gives him the assurance that he has more than just a thrift plan.

Another point that is of great importance to the worker's sense of security is his right to transfer to the employ of another hospital without sacrificing what has been paid in by his employer. If hospitals expect to get trained administrators, supervisors and other personnel from other institutions when they need them, they should look with favor on a pension plan that permits the transfer of pension benefits already acquired. This places no burden on the new employer in providing a retirement fund for the years of service this employe has given other hospitals. In this respect the plan should follow the pattern of social security.

Furthermore, if a hospital finds it advisable to dismiss its administrator, for example, it can terminate his employment with a clear conscience if it has already contributed its share toward his retirement fund for each year of service he has rendered.

For these reasons the pension committee recommends both full vesting and transferability. Contrary to the practice of industry it does not look with favor on the use of the pension plan as a means of "freezing" employes in their jobs. The committee believes, however, that a sound pension plan will influence employes to stay with their hospitals.

It is because of these features that the American Hospital Association is recommending the use of the plan worked out in cooperation with the National Health and Welfare Retirement Association. This is a nonprofit corporation set up under the insurance laws of the state of New York and managed by a group of 60 trustees under the chairmanship of Gerard Swope. A choice of two plans, one without and the other with a death benefit, will be available to hospitals in September 1946.

3. What will the cost be? Realizing that the cost must always be within control and that hospitals should not commit themselves to a rising cost for pensions, the pension committee recommends the "money purchase" plan, on which the National Health and Welfare Retirement Association operates, as distinguished from the "fixed benefit" plan usually used in industry.

Under the retirement association plan, the hospital pays a flat 5 per cent of the salaries of the participating employes plus whatever cost it determines for its own past service. In general, the cost to a hospital will probably be about $3000 to $4000 per year for each $100,000 of pay roll. This will probably not amount to more than 15 or 20 cents per patient day.

If the Social Security Act is amended, it is planned to adjust the cost of the private plan downward. The plan should always be thought of as supplementary to social security and not competitive with it.

4. Can a hospital afford a pension plan? Just as the industrialist, the labor leader and the general public have accepted the cost of pensions and retirement income for workers in industry, hospitals can now be assured of the same approval. Hospitals cannot afford to retain employes beyond their years of usefulness, and patients and the public are willing to pay for efficient service.

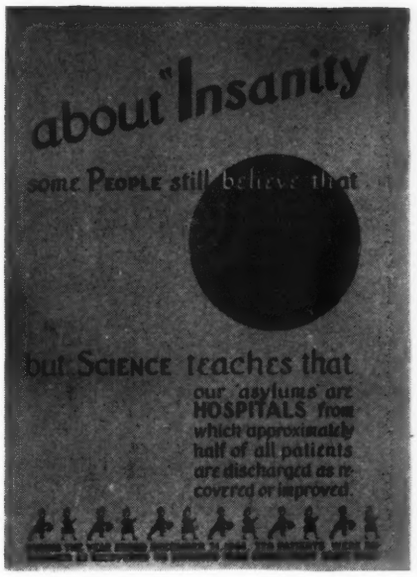
A Pension Plan Is Cheaper

From an actuarial standpoint it is cheaper for a hospital to have a sound pension plan than not to have one. With such a plan a hospital can give the employe the opportunity to contribute his share toward the cost, which he is ready and willing to do. Without a plan the hospital pays the whole cost and much of the cost is paid in inefficiency and financial outlay which cannot be budgeted in advance.

With the public acceptance of pension costs as a legitimate charge, hospital trustees may look to such sources as the Blue Cross, community chests and welfare funds, as well as to the government, for additional payments to cover this item. It may now properly be a part of the patient day operating cost.

Hospital trustees who wish to be up to date in providing security for their employes will do well to read the report of the American Hospital Association's pension committee and consult the National Health and Welfare Retirement Association about its pension plans. Its address is 441 Lexington Avenue, New York 17, N. Y.

"Open Door" Policy Admits Understanding of Hospital Problems



ALEX SAREYAN

National Mental Health Foundation, Philadelphia

WHAT is believed to have been a unique departure from the established routine of state hospital administration took place in the late summer of 1944 at the Connecticut State Hospital, Middletown, Conn., when the superintendent, Dr. Edgar C. Yerbury, established a full time public relations office.

With the aim of influencing public opinion to a sympathetic attitude toward the needs of the hospital and a greater understanding of its problems, the program was started quietly and slowly. It was the belief of the public relations staff that such a policy, coupled with an absolutely frank and realistic approach to the daily problems of the hospital, and its 3500 patients and employes, would produce the desired result.

Editorial Expresses Approval

How effective this approach has been may be seen in the following excerpt from an editorial that appeared in the *Hartford Daily Courant* on January 21 of this year. This was approximately 18 months after the public relations program received the green light from Dr. Yerbury. Although the editorial was inspired by a press release covering a newly established program of foster home care for mental patients, it was titled "Public Relations."

"Under ordinary circumstances the label 'public relations' appended to a news release sets up involuntary resistance in the mind of an editor. He immediately looks for the angle. A news release from the Connecticut State Hospital's 'public relations office' is something else again, because if any group of institutions desperately need good public relations counsel it is those housing the mentally ill. They had their beginnings in the poorhouse and they have never yet been able to shed completely their humble origins. Usually they are treated like poor relations when it comes time to fix appropriations. Almost invariably they are overcrowded and understaffed. When they make the front page, it is likely to spell trouble for them because they usually become news only when an act of violence or other trouble occurs.

"It is therefore pleasant to realize that Dr. Edgar C. Yerbury, superintendent of the Connecticut State Hospital, realizes that a man-sized public relations job must be done if the mental hospital is to receive the same attention, confidence and respect that are accorded hospitals treating physical ailments.

". . . It is good to know that the Connecticut State Hospital has recognized the value of good public relations. It is to be hoped that it will be developed on the sound basis of accomplishment, rather than being like so many public relations programs, a compound of sound and fury signifying nothing."

Aims of the Program

Several objectives for the public relation program were set forth at the beginning to help guide it into desired channels. Among these were:

1. To interpret the nature of mental illness to the public and, in so doing, to combat the widely held misconceptions and social stigma that brand those afflicted with this type of disease.
2. To interpret and report both locally and throughout the state on the activities of the hospital.
3. To interpret the needs of the patients to the public, by keeping it constantly aware of the hospital's inability to render proper and adequate care because of lack of sufficient funds and personnel.
4. To gain the confidence and support of the press and public through frank and straightforward reports of all newsworthy developments, both good and bad, at the hospital.
5. To promote harmony between the administration and employes and patients within the institution.

In developing this program the

greatest emphasis was placed on newspaper publicity although such other media as posters, motion pictures, radio, public meetings, press conferences and a monthly house organ were also used.

The newspapers without exception were cordial, sympathetic and even eager to assist the hospital in bringing its story to their readers. Many editors openly expressed their appreciation for opening up a source of news that had previously been denied them.

Carefully prepared press releases were sent regularly to local papers and to out-of-town papers and news services also if the story warranted such coverage. These covered spot news, such as special events, official visits and inspections, staff changes or such unusual cases as a patient suicide or escape.

Progress reports including quarterly admission and discharge statistics, plans for changes and improvements in plant and extension or curtailment of activities or treatment facilities for patients were also issued in the form of press releases.

New Angle on Help Shortage

One of the most notable examples of this type of publicity was a story stressing the acute personnel shortage at the hospital. This in itself was not news during the war emergency. "More help" was the theme song every public institution was piping during the war. Therefore, the story had to be presented in such a way as to capture reader interest. This was done by tying in the help shortage problem with the forced closing of two hospital units that had cost the taxpayers more than half a million dollars.

Along with the press release, the papers were given photographs showing crowded conditions under which patients were living, together with interior and exterior shots of the closed buildings and their ample facilities for relieving the overcrowding if sufficient help could be obtained. This story was given from a fourth to a third of a page in several important papers in the state.

In preparing material for publication, a conscious effort was made to keep a constant flow of news stories that would have the total effect of making the public aware that both patients and employes were people—and members of the community. This was necessary because for so many years prior to the war large numbers of itinerant attendants and institutional helpers had drifted on and off the pay roll as if they were stopping over for a brief visit.

Loyal Employes Suffered

Such people had, of course, no sense of responsibility to the community. As a result, the community had come to judge the entire personnel on the basis of their contacts with these undesirables. Good and loyal employes who were established residents of the communities suffered because of this blanket condemnation. To this end, activities of the employes whenever they engaged in community work, such as fund drives, were publicized. Recreational, religious and cultural activities of both patients and employes were likewise submitted to the papers.

To break down the sense of shame and derision felt by many of the local citizenry about the presence of a mental hospital in their community, items highlighting the constructive aspects of the hospital and its contribution to the general health and welfare of the community and state were publicized. This was done through stories interpreting the nature of mental illness, the possibilities for improvement and recovery and the successful rehabilitation of discharged patients.

Through personal contact, editors responsible for handling hospital news were persuaded to scrap such archaic terms as "inmate," "insanity" and "asylum" and to substitute for them the more scientifically accepted words, "patient," "mental illness" and "hospital."

Feature Stories Welcomed

Editors of Sunday magazine sections, always on the lookout for feature stories, welcomed suggestions from the hospital's public relations office and in several instances were more than pleased to have the public relations office prepare copy and illustrative material for their Sunday supplements. One of these articles introduced the foster home care program for mental patients through a case history presentation; another was a picture story that attempted to give a cross section of patient life at the hospital.

When there was a particularly significant story, such as the announcement of a proposed $3,000,000 building program, the need for a specialized hospital to care for senile patients or the announcement of the establishment of a foster home care program, editorial writers were sent releases as were the city editors.

To make certain that both afternoon and morning papers had alternate breaks on first coverage, a careful record of all releases was maintained. If a major story hit the afternoon papers first on one occasion, then the next important item was slated for morning release. The same policy was rigidly maintained in the distribution of minor stories.

This strict policy of impartiality gave the papers a sense of security and confidence in the hospital public relations office. As a result, the superintendent was not beseiged at all hours by calls from the papers to check on a news development. The papers came to understand that whenever an important development broke, it would be properly and adequately covered and reported to them promptly.

Press Conferences Helpful

Another approach used by the public relations office in achieving understanding between the press and the hospital was through a series of press conferences to each of which a small group of reporters and editors responsible for the hospital's district was invited. During these conferences, which took place at the hospital, frank reports of the hospital's problems, as well as future plans, were presented.

After the conference the reporters were taken on an unannounced tour to whatever sections of the hospital they wished to visit. No effort was made to cover up any of the hospital's shortcomings on these trips. Needless to say, the handling of Connecticut State Hospital news by these men was intelligent and sympathetic.

It should be emphasized that at no time did the public relations office attempt to serve as a whitewashing agency. To have done so would have been disastrous.

Only recently, the other two state hospitals have joined with the Connecticut State Hospital in setting up a public relations program that will operate on a statewide scale. The inspiration for this program came out of the experience at Middletown.

COLOR and Psychotherapy

FABER BIRREN
New York City

An authority on color reviews some of the recent developments in the psychological and therapeutic aspects of color and sets forth some practical specifications for hospitals

BECAUSE of its strong emotional appeal the general application of color to hospitals is likely to be beset by personal prejudices and preferences and by many unfounded claims. In the past many exaggerated theories have been propounded which have justified a skeptical attitude on the part of the medical profession and hospital field.

If color is to be used sensibly and functionally, it is perhaps best to forego the idea that it has any direct therapeutic value. While this point may be argued, the physical action of color or visible light on the human body has by no means been clearly proved.

It is therefore more reasonable to study color in its more psychological aspects, for here there is no denying that it has strong emotional appeal. Rightly used in a hospital, it pleases the patient, creates moods favorable to recovery and generally improves morale and mental attitude.

Effect Can Be Measured

Fortunately, measurements of the effectiveness of color are not all intangible. In human vision, for example, the causes and effects of eye fatigue may be readily checked. Ideal seeing conditions may be "engineered" in accordance with straight scientific practice and no personal judgment or debate is required to determine whether or not color has been rightly applied.

When glare, inadequate levels of illumination, severe contrasts and the like exist, eye fatigue will be apparent. The pupils of the eyes may show severe dilation. The lids may blink more rapidly. There may be a collapse in the "visual-form fields," the outer boundaries of the retina growing less sensitive. There will be increased muscular tension, apparent fatigue and irritability and perhaps headache and nausea.

Ophthalmologists and seeing specialists have been able to check these facts by means of instruments. Hence, eye fatigue is not to be mistaken, nor can the benefits of any lighting installation or color scheme be denied if it overcomes or lessens those reactions so evident when the eye is abused.

In the new science of brightness engineering, reliable formulas have been worked out to assure comfortable seeing conditions. In this application of color (largely for its brightness) right and wrong need not be confused. In fact, the fundamental principle involved is quite simple.

Parry Moon states: "Investigations of the most diverse kind show that a human being sees best and visual fatigue is reduced to a minimum when the entire field of view is approximately the same luminosity as that to which the fovea [center of the retina] is adapted."

Matthew Luckiesh has further shown that brightness ratios smaller than 1 to 5 are desirable; ratios higher than 1 to 10 should be avoided. If these requirements are met, hospital color schemes will be essentially right and quite beyond technical criticism.

Theories of interior decoration often run contrary to the principles of brightness engineering. If for the sake of "dramatic" effects, the patient must look alternately at light ceiling, dark floor, severe contrasts in walls and furnishings, constant pupilar adjustments may be demanded which will cause unmistakable distress.

When proper attention is paid to brightness ratios, all areas and surfaces regardless of their hue will be more or less uniform in brightness. Ceilings should be tinted to relieve glare. Walls should be neither too light nor too dark, perhaps with a reflectance of about 50 per cent. Flooring materials, furniture, draperies should average not less than 20 or 25 per cent in brightness.

If the variety is in color, not in extreme lightness against extreme darkness (and if the illumination of the room is fairly uniform), there will be little or no eye fatigue and prolonged occupancy will not cause discomfort.

Special Value in Surgery

This engineering of color holds special value in surgical departments where critical seeing tasks are performed. Walls, if anything, should be a trifle deeper than are working or operating areas. Mr. Luckiesh states: "It may be concluded that brightnesses somewhat lower than those of the central field are generally most desirable. All experimental evidence indicates that peripheral brightnesses higher than

those of the central field are definitely undesirable."

The use of blue-green in operating rooms, medium in tone, helps to reduce glare, aids visibility and, at the same time, heightens perception of blood and tissue through visual complementation. White here is obviously to be avoided, particularly if it is brightly illuminated.

Brightness engineering is a relatively new science, given impetus and importance during the war when severe eye tasks were encountered throughout industry. It has brought into the art of color a number of accurate principles and rules which are subject to measurement and which make it unnecessary to rely upon highly fugitive opinions or artistic "feeling." This sure approach has long been needed to divest color of its mysteries and to put it to work with real competence and assurance.

Further and significant work has been done in the field of color by a number of investigators. These studies again suggest a functional approach that sidesteps empiricism and relies upon scientific method in determining why and how color should be employed. Research, of course, is the only sound basis for any application of color which is meant to serve a purpose that goes beyond mere appearance.

Colors Are Warm or Cool

In the main, the colors of the spectrum divide themselves into two major regions: warm hues, such as red, orange and yellow, and cool hues, such as green, blue and violet. The neutral point is in yellow-green. All radiation striking the eye or the body appears to create a tonus condition (muscular tension).

Reactions are in two directions. With warm hues there is an attraction to stimulus. With green and blue there is a withdrawal from it.

Kurt Goldstein writes, "We find that green favors performance in general, in contrast to red. The effect of red probably goes more in the direction of an impairment of performance." This would mean that green (and blue) more or less is conducive to normal activity and response, while red (and orange) is more impulsive and distracting.

It is also known that under the influence of warm hues time will be overestimated and weights will be judged as being relatively heavy. With cool hues, time will be underestimated and weights will be judged as being relatively light. Goldstein asserts: "Under red and green lights, movements are carried on with a different speed, without subjectively experiencing the change in speed. Likewise, the estimates of traversed distances, time intervals and weights are judged differently under the influence of different colors."

Warm hues, being exciting, tend to "pack" more experience into a given period of time, while cool hues have a contrary effect. Feré noted that muscular tension increased from a normal 23 to 42 under red light, while with blue the increase was only from 23 to 24. Similarly, Gilbert Brighouse showed muscular reactions to be 12 per cent quicker under red light, while green light had a retarding influence.

Such investigations would justify a practical attitude toward the use of color. Warm tints become appropriate for solariums, corridors, parlors and private rooms devoted to maternity patients. Cool hues, because they tend to relax the mood and make time "speed by," become appropriate for facilities devoted to chronic disease patients and to utility and working spaces in general.

Many interrelations exist between color and the other senses of the human body. S. V. Kravkov writes: "We may consider it an established fact that the color sensitivity of our . . . vision is dependent in a definite way on the condition of the autonomic nervous system."

From his work, later confirmed by Frank Allen and Manuel Schwartz of Canada, "it may be safely inferred that stimulation of any sense organ influences all other sense organs in their excitability." In brief, stimulation of the retina, the influence of loud noise, strong odors and tastes depress sensitivity to red and increase sensitivity to green.

Today color preferences and emotional reactions to color are finding plausible explanation. The functioning of the endocrine glands may help to account for seasonal variations in likes and dislikes for color: tints in spring, shades in fall.

E. R. Jaensch has related the effect of red radiation, predominant in the tropics, to pigmentation of the retina and to the general preference of brunet types for red hues. Conversely, retinal accommodations to ultraviolet light in more polar regions may account for the general preference of blond types for greens and blues.

These studies and speculations began to lead from psychologic phenomena to things physiologic. It has long been recognized that the body, aside from vision, has a radiation sense. Blue radiation affects only the superficial layers of the flesh, while yellow and red penetrate more deeply. In experiments performed by Dr. Mizutani of Japan (1940) red was found to accelerate the healing of wounds, while blue retarded it. "As for the effects of visible light upon tumor tissue within the body, red rays affect to prevent the growth and blue rays affect, though slightly, to accelerate it."

Color Can Be Used Rationally

However, it is no doubt safest and wisest to forego the attitude that color has any direct therapeutic benefits in its action upon the human body. To accept it in the realm of psychotherapy is fully defensible and perhaps sufficient for the purposes of hospital decoration. There are enough reliable facts and plenty of functional reasons to apply color rationally and not merely esthetically.

When the color program has its basis in such measurable technics as brightness engineering and in evident human responses to warm hues as against cool ones, resultful specifications are to be written and the needs of the hospital are well served.

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The Case of Dietitian *versus* Hospital Field

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IN LAST month's article on this survey of the reasons why an increasing number of dietitians is leaving the hospital field for other types of positions, various features of the job and the dietitian's problems in the hospital were reviewed. The following discussion will analyze salaries and opportunities for advancement.

Salaries. The chart on page 60 of median salaries and salary ranges has been compiled from figures of the 86 hospitals that returned questionnaires. The median salaries are the middle figure for each group. Consequently, half of the hospitals of each group pay more and the other half pay less than the median salary. (Medians should not be used as a basis for determining salaries.)

This summary shows the wide variation in salaries. There seems to be no one factor determining salary in any institution. The range in all sizes indicates lack of uniformity in policy concerning salaries; this is probably reflected in similar lack of policy concerning qualifications for dietitians. Salaries of all types of dietitians are low in some hospitals and, on the other hand, salaries of head dietitians are good in some hospitals of all groups.

There is a noticeable spread between the salaries of head dietitians and those of administrative assistants; this probably accounts for the turnover among these assistants. Good salaries at the top may hold the dietitian and there is little chance for promotion or salary inducement in positions below the headship. It seems desirable to increase the salaries at some of the lower levels in relation to that of the head dietitian.

SCHEDULE OF A GROUP A VOLUNTARY HOSPITAL

Head dietitian	$250–up	Experienced
Administrative assistant	$200–$250	Experienced
Therapeutic and other supervisory positions	$165–$250	Experienced
	$135–$165	Inexperienced up to three years
Teaching	$200–$250	Experienced
	$150–$200	Inexperienced up to three years
Ward	$135–$165	Inexperienced
Other	$135–$165	Inexperienced

Maintenance is furnished in addition to these cash salaries.

SALARY SCHEDULE IN A GROUP B PUBLIC HOSPITAL

Head dietitian	$3000–$3600
Instructor	$2800–$3200
First assistant	$2400–$3000
Staff	$1800–$2400

Maintenance is furnished in addition to the cash salaries.

The two schedules shown above illustrate desirable balance.

A number of head positions in voluntary and public hospitals in groups B and C run from $4500 to $6500. In these institutions there is likely to be a wide spread between top and assistant positions.

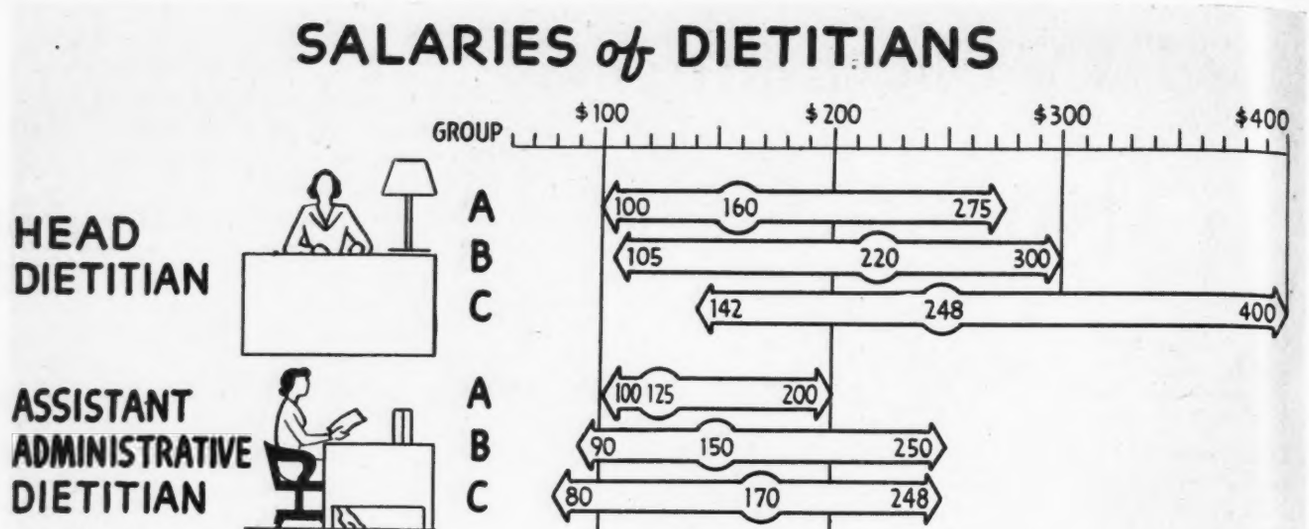
Our study indicates that hospitals of the same type and size within a given location pay comparable salaries. Less than 5 per cent in any group report lower salaries than other hospitals in the community; several hospitals state that their salaries are higher. It seems, therefore, that dietitians leaving for reason of salary go to different types of, or larger, hospitals or to positions in other fields.

An approximate percentage in each group, 34, 20 and 28 of A, B and C, respectively, state that dietitians' salaries are lower than those of other professional hospital staff members; 10, 23 and 10 per cent pay higher salaries to dietitians. Qualifications, responsibilities and other factors determine fair salary rates for all staffs but when well qualified dietitians are paid less dissatisfaction always results.

Salaries in upper ranges as reported in this survey compare favorably with the average salaries in competing fields if value of maintenance is added. There are, of course, some positions in these other fields which attract the able and highly experienced hospital dietitian at salaries outside the possibilities of most hospital budgets, but such positions are not numerous at this time. When dietitians leave head positions, therefore, it is because some of the factors discussed, other than salary, carry sufficient weight to determine the change of work.

Salaries at low and middle ranges in all groups are below those in competing fields and there is every reason to believe that they do not provide sufficient inducement for capable dietitians to remain in the field. One of the interesting facts in connection with the question on comparative salaries is that 60, 53 and 65 per cent of A, B and C, respectively, replied that they do not know how salaries in their hospitals compare with those of dietitians in other fields.

Good salaries are now offered in public hospitals, but even though the salary range and provisions for security are higher in these hospitals, including army and veterans', there is considerable unwillingness among able dietitians to enter this field.



It is likely that conditions which were the result of the pressure of war account for the unwillingness of many army dietitians to return to the hospital. Dietitians were added to the army rather than absorbed by it so that many of the duties which they carried in civilian hospitals had already been assigned to mess officers, mess sergeants and others.

Some commanding officers used the abilities of their dietitians to the fullest extent but not all dietitians were fortunate enough to be assigned to these stations. They regretted that they were unable to contribute such knowledge and experience as they possessed to situations where these were obviously needed. For the inexperienced dietitian, of course, any opportunity was a valuable one for her professional development.

The Veterans Administration has given assurance that properly qualified dietitians will have complete authority and responsibility for food service in veterans' hospitals. This recognition of the administrative ability of experienced dietitians and the location of these hospitals near civilian medical centers make this field increasingly attractive in all phases of dietetics, according to a statement by the chairman of the dietetic advisory council of the Veterans Administration.

Much of the attitude of dietitians now employed in some state and city institutions is entirely understandable after interviews with them. In many of these hospitals the dietitian has had no status and little responsibility. She is frequently responsible to an untrained steward who may owe his appointment to political connections. Buying or requisitioning is usually done by the steward; personnel is employed by him or is on a type of civil service appointment which makes it difficult to get rid of unsuitable employes.

Standards of food, food service and equipment are frequently deplorable, yet the dietitian's duties may be confined to preparation of a few special diets and supervision of food for the staff. Exclusive of army and veterans' services, approximately 78 per cent of all hospital beds are in public institutions. This is the great field for dietitians, the most difficult, the least developed and the most rewarding from the standpoint of public service.

Because of salary and security it will always be possible to employ dietitians, but unless the strongest people in the profession can be persuaded to enter this field, we shall fail to develop the best dietary service for the great majority of the people. It is important that adjustments in duties and responsibilities, as well as qualifications, be made in order to attract able, experienced dietitians.

Miscellaneous Comments. "Too much routine which does not require a trained dietitian" is the complaint of many, especially of the younger dietitians. Other comments are "no chance to develop initiative"; "too

many thing are rigidly fixed in the hospital program; it is not possible to develop the dietary service to an extent that would demand all the abilities and resources of the dietitians"; "too busy to study the job and develop it properly"; "emergency conditions are allowed to continue indefinitely so long as the dietitian is willing to put up with them"; "anything for the 'front of the hospital' but not for the 'back of the house' "; "not enough staff"; "not enough help." Others regret that they never see the patients in whom most hospital dietitians are primarily interested.

Need for Better Dietitians. The problem of turnover among dietitians, however, cannot be discussed from the standpoint of hospitals, and hospital administration only. Dietitians themselves create many of their own difficulties. It is apparent from our interviews and from many comments by superintendents that dietitians might be happier in hospital work if they were better dietitians.

Some are incapable of handling their wide responsibilities; they lack resourcefulness. Of course, they are unhappy and leave at the earliest opportunity. The hospital is not the greatest sufferer from this type of person; she lowers professional standards and makes it difficult for those who follow her to build confidence again in the dietitian.

Many of the reasons given for leaving the field are admissions of immaturity. Girls coming into this field are frequently unprepared for hospitals as they find them. They expect utopia and are not acquainted with essential aspects of their work. They do not realize what every girl going into nursing would take for granted, *i.e.* that patients are sick twenty-four hours every day in the week and that such an essential service as food must therefore operate to serve patients and the staff that cares for them at all times. They are therefore dissatisfied when they are assigned to late shifts, when hours are uncertain and irregular and when the emergencies that constantly arise demand shift of regular assignments.

Evidences of immaturity are likewise reflected in the self centered attitude of many young dietitians coming from homes and schools in which everything centers around them. They must immediately adjust to an organization in which they must cooperate with all the staff in serving others. It is probably too much to expect this adjustment to take place smoothly but the worst evidences of lack of adjustment might be avoided by wise guidance within the institution.

Many young dietitians finding the work disagreeable and the administrators indifferent quit and go home. Or they try another job, which they also leave because leaving is easier than solving the problems they are sure to find. They expect the hospital to assume the responsibility for their social life and their personal reactions. They frequently lack resources within themselves to succeed professionally and to make their lives broad and satisfying.

Without question, the security of hospital work has attracted some of the less capable dietitians and many who lack ambition are content to take conditions as they are and to do little to improve them. They do not develop the department and the hospital suffers in the long run though the administrator may be spared temporary annoyance.

Administrators comment on the fact that they find personality problems among their dietitians from time to time. They find that dietitians who have good technical training "do not cooperate with other department heads," "do not wear well," "irritate employes," are "inflexible," "do not have pleasing personalities," are "colorless and ineffectual."

Such problems are not limited to the hospital field but they are especially unfortunate here because of the variety of contacts the dietitians must maintain. Some of the difficulty may be eliminated by clear-cut lines of authority and the establishment of definite responsibilities and by the administrator's support of the dietitian in all areas of decision assigned to her but, in the long run, persons with difficult personalities should be eliminated from administrative work and from contacts with patients; they cannot be fitted into the hospital organization.

Many administrators state that they are greatly in need of dietitians on whom they can depend for fine management, good teaching and expert work in diet therapy and that they are unable to find enough adequately trained, poised women to fill their positions.

This is the second of three articles on the problems of dietitians in the hospital field. The concluding article will appear in the September issue.

SALARY SCHEDULES IN VARIOUS PUBLIC HOSPITALS

VETERANS' ADMINISTRATION

Grade	Salary Range
P-1	$2320–2980
P-2	2980–3640
P-3	3640–4300
P-4	4300–5180
P-5	5180–6020

Grades P-1, P-2, P-3 apply in hospitals and P-4 and P-5 apply in the 13 branch offices.

U. S. ARMY MEDICAL DEPARTMENT

Rank	Annual Base Pay	Monthly Rental Allowance	Monthly Subsistence Allowance
Lieutenant (2d)	$1800	$45	$21
Lieutenant (1st)	2000	60	21
Captain	2400	75	21
Major	3000	90	21

For each three years of service up to thirty years the base pay is increased by 5 per cent. Base pay is increased by 10 per cent for any period of service beyond the continental limits of the United States or in Alaska. The rental allowance is given in lieu of suitable quarters on a post.

NEW YORK STATE CIVIL SERVICE STANDARDS

Title	Base Salary	War Emergency Salary
Dietitian's aide	$1400–1900	$1820–2394
Dietitian	1650–2150	2079–2623
Senior dietitian	2000–2500	2440–3050
Supervising dietitian	2400–3000	2928–3540

Evaluation reports must be accurate

To Help the Hospital Recover

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THE importance of evaluation reports, evaluation engineering and appraisals of physical property owned by any hospital is a subject that has many diversified points for consideration. In this discussion we are concentrating on the use of these reports to determine the correct amounts of insurable values in order to protect the hospital adequately against direct losses, such as fire and earthquake. Insurable value is but one of many kinds of value:

The investor is interested in income or economic worth.

The lender wishes to know the low or lowest probable future value of the property so that the obligation can always be quickly liquidated.

The industrialist considers going concern value as he is interested in the property as a tool to produce goods.

The dealer buying distressed property will pay only salvage or forced sale value.

The accountant quite often sets up the accounts of his corporation on a book value which, in many cases, is predicated on tax requirements and often has little relation to the true worth of the asset.

There are many other concepts of value, depending always upon the use or reason for determining its worth for a specific purpose.

Insurable value, which we are to consider, is another of this family of values. It is predicated primarily on the terms of the insurance policy. Insurable value is really depreciated replacement cost. It is the amount the assured may recover under the terms of his insurance contract if his assets have been correctly appraised and underwritten.

The property may economically have greater or less use value to the owner than the amount for which it is insured, depending upon its income producing power, but direct insurance is not based upon economic return.

Presented at the meeting of the Association of Western Hospitals, May 1946.

Accurate insurable value is essential to proper fire insurance underwriting. If the insurance policy amounts are more than the insurable value of the property, the hospital not only is wasting money in premiums for excess coverage but, in the event of a loss, is likely to be embroiled in argument if not in litigation with the insurance company. On the other hand, if the protection is not sufficient to cover the hospital, its management will receive unfavorable criticism and publicity.

If the policies are so written that there is a reduced rate average clause or percentage co-insurance clause, making the hospital a co-insurer or in agreement to carry a certain percentage of insurance to the value of the property, even a relatively minor loss can prove embarrassing.

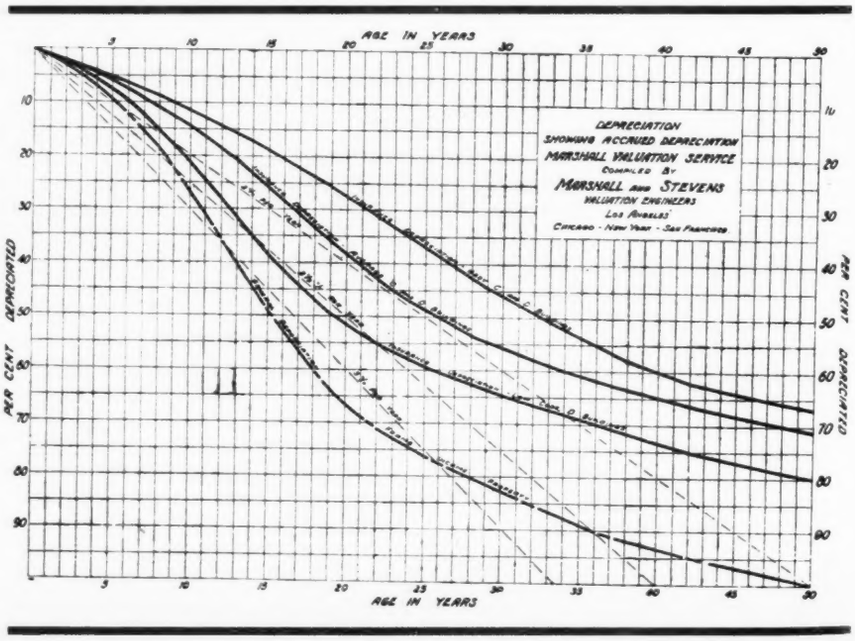
For example, if a hospital is carrying $100,000 worth of insurance with a 100 per cent co-insurance clause and if this valuation is based upon insurable values of 1940, this hospital, on today's market, is quite heavily underinsured and a loss of any amount would not be covered to its full insurable value.

The process of determining insurable values, as determined by a qualified valuation engineer, is as follows:

Two methods may be used to determine fundamental replacement costs which are always the bases of all insurable values.

The first, and simpler, is a comparative method based upon the original construction cost or a detailed estimate made at an earlier date. To reduce this to its present day equivalent is only a matter of applying a simple percentage factor from a standard table. Unfortunately, in the majority of cases, there are no known costs to work from and also many changes and alterations have been made; in these cases a less simple, but usually more accurate, method must be followed.

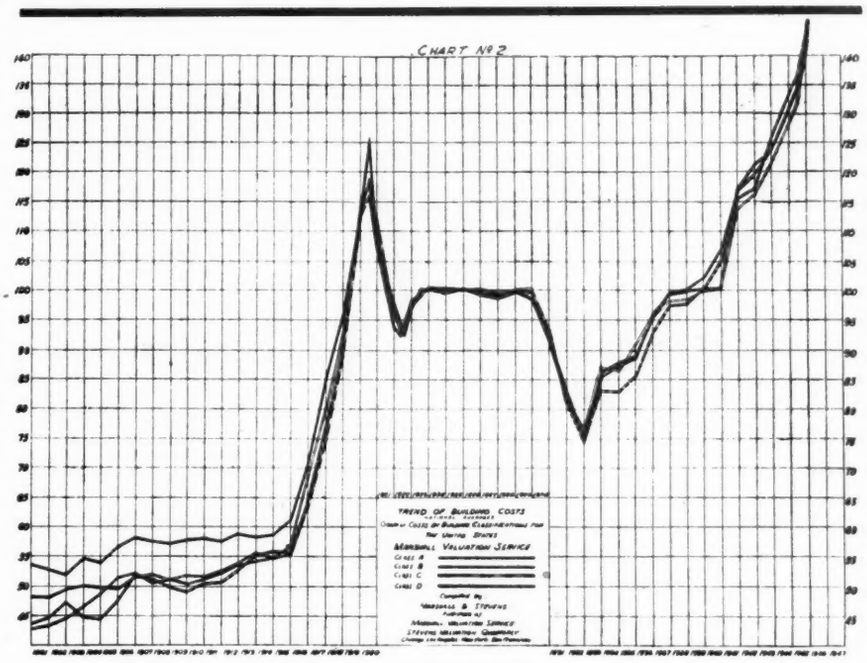
To determine the replacement cost of a structure from the building itself, four steps are required. It is necessary first to survey the building to obtain the basic data needed; then to compute the replacement cost from this information; next to estimate the amount of depreciation to ascertain its present sound value.

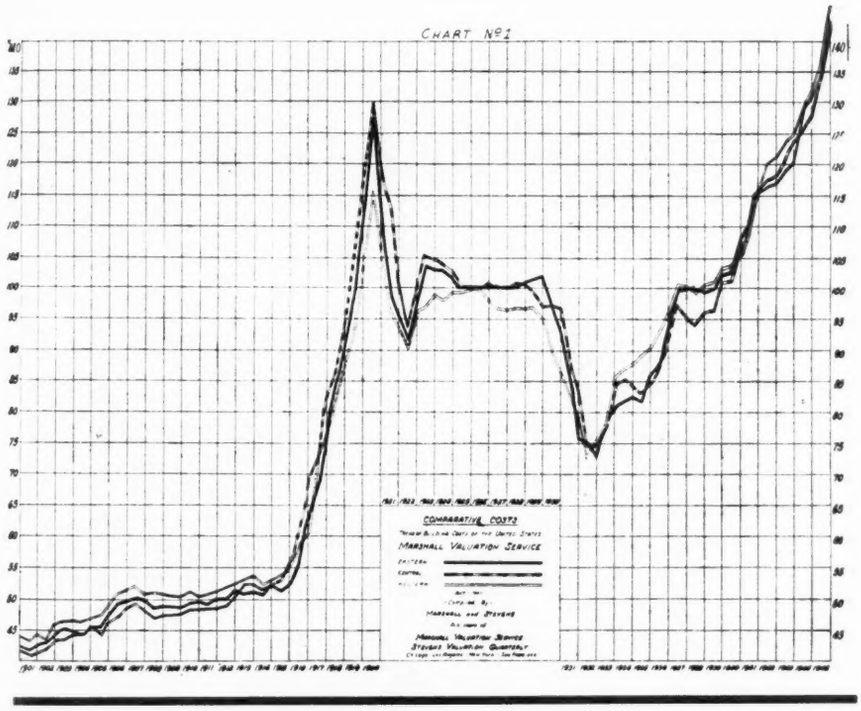


and, last, to determine and deduct for unburnable excluded items in order to arrive at its insurable worth.

The first of these steps, which is the building survey, should be undertaken using a definite outline or blank so that all items of importance may be noted. These include size of basement, area of single floor, number of stories, wall heights, type of finish, kind of floors, materials used in construction, type and style of roof, heating, plumbing and special features. If these data are carefully noted and classified, the work need not be completed at the building but may be performed at a later time.

The second step is to find the replacement cost. Many methods of computation may be used. These begin with the simple square or cubic foot estimate. From this we proceed through many refinements to the detailed piece bill of the contractor in which every item is counted and priced. Between these two extremes is a middle ground where reliable estimates may be made by using improved methods without the effort required to produce a full bill of labor and material.





The unmodified square foot method often produces low costs owing to the lack of consideration of wall heights, and the cubic foot method may result in high worth because of overemphasis on height. It is in the middle ground that most insurance appraisers work, and for them it is the most practical field. A full piece bill is seldom necessary to determine building costs within reasonable limits of accuracy.

If the principal parts of the building are separately listed, based upon their area and unit price using reliable standards, the results are bound to approximate its true replacement cost.

In computing the areas of a structure, great care must be taken to see that the sizes are correct and that the measurements are close. (That is, the opposite sides are equal in total length.) Preferably these sizes should be rechecked at the building so that any error can be corrected by remeasuring. Particular attention should be given to story heights as in special structures, such as churches and theaters, these heights may more than double the cost of the auditorium. It is always well to recheck all areas on the basis of overall dimensions to be sure no major error has been made. The insurance maps are helpful for rough estimates and rechecks but should not be relied upon in detailed work. Many important construction features from the standpoint of value are not shown on maps; also additions may have been made to the building since the map was made.

The third step is to compute the depreciation. Even the best of appraisers can argue for days over this subject. Annual tables are valuable as guides and show the usual trend of depreciation. Given percentages per year are often used and are a fair guide, but these usually give too much depreciation in the early life of the building, too little in the middle period and, again, too rapid depreciation at the end of the building's life. Actual depreciation, if platted, is not a straight but a reverse curve. The chart on page 62 shows the point graphically.

Another good way to measure depreciation is to try to determine the amount of the building's life that has already been used; how long it has been in use, and how much longer it will be usable. Obsolescence, while

it should be given consideration, is a minor feature.

The sound value of the structure is quickly computed by subtracting the estimated depreciation from the replacement cost. This sound value represents the present worth of the structure as it stands today.

The fourth step is to estimate the unburnable parts, which are to be excluded from the insurance coverage. These include foundations, underground piping and other construction not subject to fire damage. The architect's plans and specifications may be excluded if they are available and usable.

The architect's supervision should never be excluded as it will have to be undertaken again if the building is replaced.

Serious thought should be given to the existing conditions in each case before masonry walls and floors are excluded. Even if one side is in contact with the earth, the other may be subjected to so much heat that it is likely to be seriously damaged. Many exclusions are not carefully thought out and, as a result, items are often excluded which would have to be replaced in case of a loss.

After the exclusions have been determined, the insurable value is quickly found by subtracting the excluded amount from the sound value. It is on this basis that the insurance should be written.

The importance of frequently checking insurance values after they have been determined cannot be overstressed, as shown by the graph on page 63. Replacement costs should vary widely over a short period and be frequently checked by standard comparative tables.

The employment of a qualified valuation engineer has long been recognized as the best method for determining insurable values of buildings and equipment. His reports also have considerable value in conservation and protection of buildings and equipment from the standpoint of maintenance and repair schedules. Also, if management is to utilize the physical properties, it must know of what these properties consist and where they are located.

In the May issue of *Science Illustrated,* Gerald Wendt in editorial comment makes the following statement in part: "What distinguishes a scientist's thinking from ordinary thinking is that when a new conclusion is inevitable it must be accepted, *whether one likes it or not.* One small youthful fact can slay any impressive aged theory."

Hospital administration is constantly becoming more and more of an exact, and exacting, science. As such, it needs to have correct and sufficiently detailed information about its plant and equipment to be able to utilize everything that it controls to its highest efficiency and to protect and conserve it by well planned maintenance and repair schedules and by sufficient insurance protection to cover any direct losses.

Teaching Is a Major Function

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THE demobilization has rendered acute the problem of postgraduate medical education. It is not a new problem. During recent years it has been one of increasing concern to the members of the intern committees of hospitals approved for intern and resident training for this phase of the postgraduate training problem is perennial.

At present the desire of the returning medical officer for training of various sorts has overtaxed the capacity of our schools and hospitals alike. Many of the returning physicians find classes filled and house staff positions of the desired sort unavailable. The university affiliated hospitals which to a large extent have carried the task of postgraduate teaching cannot meet the present demand. It would, however, be an error to regard the present situation merely as a passing emergency.

New trends in medical education in the direction of specialization and in the standards being set for specialist certification call for expanding opportunities for postgraduate work. In particular, there is present need for alteration in the ratio which has existed between junior and senior house officers. The number of graduates in recent years has been much smaller than the number of first year internships offered. This condition will probably exist for some years into the future.

On the other hand, there has been an increasing demand for senior house staff positions quite beyond the number available. The candidates for these senior positions need and should have opportunities for specialist training which such positions provide. They can, moreover, render valuable service to the hospital.

The university affiliated hospitals with their large staff of full time teachers will probably always play a large rôle in meeting changing postgraduate needs but I cannot see that they can play the major rôle if the task is to be carried through adequately. It will be incumbent upon the profession to maintain such staff organization and teaching facilities in the nonaffiliated hospitals as will permit them to serve in their proper spheres in the training program.

Much has been written in recent years about the educational program of hospitals and the superior quality of medical practice in hospitals conducted along university standards. The case for such a program has been too well recognized and approved to need restatement here. Experience has abundantly demonstrated that only with this orientation can the prime purpose of the hospital, the welfare of the patient, be adequately served. How can the opportunity be met and our program extended and perfected?

The American College of Surgeons has done much to establish minimum standards and schedules of hospital organization, and the A.M.A. has carried from year to year its pro-

gram of certifying hospitals as to suitability for various types of postgraduate teaching. But education is not merely a matter of standards and schedules. It depends upon the conviction of all concerned, medical staff, nursing staff, administrator and board, that education is a major function of the hospital and intimately related to the problem of patient welfare.

Many prophets predict an increasing importance of the hospital as a center for all medical activities because of the advantages inherent in the group practice of medicine. The strategic and natural place of the hospital as the nucleus for such practice was pointed out some years ago by the Committee on the Costs of Medical Care.

If hospital practice continues to increase in volume and in ratio to population and if the suggestion, now merely whispered, that any future government medical insurance plan be organized around hospital outpatient clinics becomes reality, then hospital standards will indeed be a matter of vital concern to everyone. It would appear axiomatic that if a hospital is to maintain these proper standards staff membership must carry with it certain definite obligations. It means a staff of physicians devoted to the ideal of teaching, willing to give of their time for that purpose.

Good teaching and scientific accomplishment are matters of long term planning. They are not achieved overnight. A shifting policy based on expediency cannot succeed. Clinical conferences and staff rounds must become a matter of established routine and faithful attendance upon the part of each staff member should be considered as an index of his interest in the general hospital welfare.

Adequate case histories and clinical notes must be a joint responsibility of the attending and resident physicians and not a unilateral duty. Staff appointments will have to be made with these implied obligations in mind and tenure should depend upon their faithful observation.

The number of patients referred for hospitalization has often been the gauge by which a board of directors estimated a physician's interest in the hospital. It has been a widely practiced method. Whether such a gauge really accomplished any worthy purpose is questionable. Whether it will do so in the future seems even more debatable. The most that could be said for it in the past was that it was a fairly effective method of meeting the hospital's budget and ensuring a favorable bed occupancy.

Bed occupancy, however, is no longer a problem nor is it likely to be in the foreseeable future. Blue Cross plans have been a large factor in solving the problem. These plans have every prospect of expanding their enrollment so that for a long time the need for hospital beds will exceed the supply.

Eventually some form of government subsidy or insurance will probably devise a reasonable system of financial support of a steadier sort than has existed previously. Whether it will be adequate as well as steady will depend upon factors which need not be discussed here.

National medical practice legislation, if enacted, may have a direct effect upon hospitals and hospital standards. It would be useless to debate here the prophecies both dire and felicitous which have been voiced on the subject. Of more immediate concern are the rapidly multiplying insurance plans, fostered by medical society and other groups, which aim to supplement present Blue Cross plans with payment of medical fees or some part of them for service rendered within the hospital. This trend will increase still further the demand for hospital beds; it will, moreover, tend toward an increasing request for these beds by physicians who heretofore have made limited use of hospital facilities.

How will this affect hospital standards, intern teaching and like problems? The answer will depend upon the zeal with which standards are maintained and improved. It will depend upon the conviction of those responsible for hospital policies that good educational standards are a cardinal consideration and indispensable to good medical practice. With such an orientation, we can look to the future with confidence.

Say It With A Smile

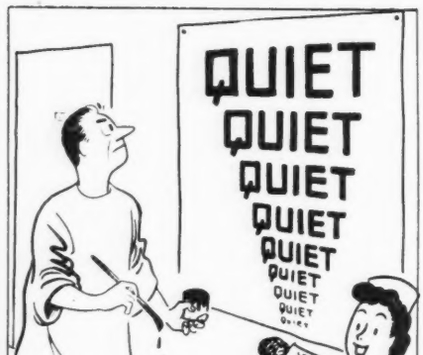
STRONG Memorial Hospital of the University of Rochester, Rochester, N. Y., has been using comic cartoons successfully for the education of visitors. Persons who became myopic when confronted with the usual type of sign or poster stop to look at cartoons, usually get the point, laugh and accept the hint without resentment.

The use of such cartoons was part of a drive to protect patients from thoughtless visitors and to prevent the useless loss of time and energy of the nursing staff and nonprofessional personnel caused by visitors who are indifferent to hospital rules.

A survey was first made among doctors, nurses and patients. It indicated clearly the damage done to patients by inconsiderate visitors and their need of protection. It showed also that nurses were forced to give time and energy to visitor problems that were needed for necessary nursing care. Since the welfare of the patients was more important than the demands of visitors, an attempt was made toward adequate visitor control.

A certain amount of contact with the outside world is beneficial to pa-

"That's for the visitors who are motorists."



"I wonder if he's an optometrist?"

"Would you help me get these flowers into that room?"

tients but although visitors provide this contact, the reaction of most of the doctors questioned was, "If I had my way I would allow no visitors in the hospital."

Here were the main reasons for this reaction: Rest and quiet are two important recovery factors after a severe illness or operation. Visitors can exhaust patients physically. Visitors often disturb patients emotionally. Visitors bring infection to patients. Visitors take the time of medical and nursing staff that should be given to patients.

The nursing staff added these indictments: Visitors interrupt and delay treatments and nursing procedures. Visitors ask questions and make requests of nurses who are measuring medicines and working on charts. They disobey visiting rules and hospital regulations and make unreasonable demands. They are noisy, smoke and chat in the corridors and rooms and visit from patient to patient.

From the public relations staff came the report that almost as many trouble calls came from patients asking for protection from wearisome visitors as for special visiting privileges for relatives and friends. The attitude of relatives, that patients would suffer and be unhappy if not visited frequently and at length, was usually a selfish one, not shared by patients in general. The exceptions were the cases of chronic illness and convalescents.

Based on this survey every means possible was used to improve the situation. Visiting hours were shortened and made uniform for all classes of patients. A large and efficient traffic control system was staffed with volunteer aides. Information literature giving hospital rules for patients and visitors was placed on the bedside table of every newly admitted patient where it could be read and studied at leisure. Radio broadcasts appealing to the public for cooperation were sent out weekly by the Rochester Hospital Council and these, in turn, were used as spots by local newscasters and commentators.

While there was a noticeable improvement in visitor conduct it still was obvious that many persons could not understand or accept the fundamental reasons for visitor restrictions. During this drive a patient clipped a cartoon out of a periodical and gave it to a member of the public relations staff. It shows a patient siting on the floor outside his hospital room which is filled with noisy, laughing visitors. He is saying to a shocked nurse, "When Are Visiting Hours Over?" A head nurse asked if she could have an enlargement of the cartoon to hang in her corridor.

"This rest and quiet is just what you need!"

Remembering the high readership rating which humor panels have in newspapers, the administration obtained permission from the publisher to use the cartoon. Enlarged copies were made and exhibited in the open-top frames hung in the elevators, corridors and offices of the hospital. The idea was a success with both visitors and staff. The cartoon attracted attention where signs failed and placed emphasis on the needs of patients rather than on arbitrary hospital rules.

Next a "Little Lulu" cartoon was used stressing, "Quiet Please!" Planned to subdue the noise of clicking heels and loud voices of visitors, it reacted on thoughtless staff members as well. Cartoon collecting has become a hobby of the hospital and enough material is now on hand to permit a frequent change of subject.

Under normal conditions a watchful nursing staff can prevent much of the damage done by relatives and friends who disregard visiting rules and make unreasonable demands. But with the present shortage of nurses, there is little time for more than good professional care of the sick and injured. Strong Memorial Hospital has found that comic cartoons are a valuable help in gaining the cooperation of visitors.

It Wasn't as Bad as We Feared

What people in the hospital world did worry are worrying and will worry about

LUCIUS W. JOHNSON, M.D.
San Diego, Calif.

THE turtle is lauded as an example for us to follow just because he sticks his neck out when he wants to go places and see things, but there are no reliable data to show how often he merely gets into trouble without accomplishing anything really worth while by this maneuver. My contention is that the armored reptile usually reaps the just reward of his temerity, as you or I do, and here is an example.

Back in 1942 I wrote several articles recounting the new and acute problems which faced the hospital administrator, with dire predictions of what lay ahead in the dark days of the war which was just getting under way. As a fitting punishment for my rashness, the editor has now suggested that these predictions be reviewed, to see how they worked out, and if the hollow tones of the prophet are still without honor. Mr. Kipling must have undergone some such infliction as this when he wrote that, "The toad beneath the harrow knows exactly where each tooth-point goes."

What's Worrying Them

In order to get a proper slant on this the plan was adopted of interviewing all possible persons who might have firsthand knowledge of any aspect of hospital problems. Three months of this have produced a great mass of material from which the following ideas have crystallized, some of them having little relation to the editor's original idea. They are not original or new, merely a sort of consensus, what the people in the hospital world are worrying about.

Government aid went a long way to temper the wind to hospitals. Priorities in food and materials averted shortages that once seemed inevitable. Help in obtaining funds and materials under the Lanham Act reduced the critical shortage of hospital beds to an appreciable extent in many war-expanded communities. Contributions from charitable persons for support of voluntary hospitals held up better than was expected, bolstered by tax laws which made donations almost painless for those in the upper income brackets. But it was necessary to learn to go without many things that once were thought to be essential.

Noncorrosive metals disappeared from the market about the time that the dreaded word "priorities" began to be whispered through the land. A number of inadequate substitutes were provided, such as those plastic fittings which came to be almost as much hated as spam in our Quonset hospitals overseas. Now, however, the shiny metals are available once more and hotels as well as hospitals are able to revamp their culinary and other equipment.

Jobbers state that ranges, refrigerators, sterilizers and laundry machinery of the preferred types can now be provided with little delay. Special metals for surgical instruments and other appliances are once more freely available. How many remember the Japanese surgical instruments with which the country was flooded after World War I? They looked like the real thing but would bend or break when one tried to use them.

Wholesale pharmaceutical houses are prepared to bring out a whole host of new council approved medicaments as soon as they can complete conversion and regain their detail men who were called to the colors. Complaints are heard from some of them that a large part of the business in penicillin and other antibiotics has been lost to the large distillers who have gone into production on a huge scale.

They also note with alarm that the big packinghouse companies are gobbling up the cream of the trade in glandular products while vitamins, a hundred million dollar business, is drifting into the hands of numerous irresponsible, fly-by-night concerns. Many of these are said to be able to avoid any control under the Food and Drug Act by operating only within individual states.

It was both interesting and exciting to sit in as an outsider and listen to a group of detail men from wholesale drug houses while they relaxed over their drinks and discussed freely the morals, policies and qualifications of the purchasing agents of various hospitals.

As the Salesmen See Them

Some administrators would be shocked if they could view their institutions from this angle. Even when taken with the proverbial grain of salt, and with due consideration of the source, there would be much to ponder. Some are said to buy certain items because of their high quality, others choose always the cheapest without regard to potency and many make their decisions on the basis of personal profit.

In a large city the representatives of several wholesalers agreed that there was only one local hospital where the doctor could be sure that his patient would get the preparation that was ordered. Substitution without telling the doctor appeared to be the rule in the others.

The shortage of workers in hospitals proved to be even worse than

was predicted and no reminders of this are needed. At a hospital council meeting I heard an administrator say, "We are taking boys off the street, putting shoes on them and paying them 90 cents an hour for work as ward orderlies, which is more than we are paying the nurses, with their years of training and experience. The nurses don't like it and neither do we."

The hospitals had to compete with the inflated pay levels of war industries and it often seemed that none but submorons could be had at any price. Some improvement is now noted. One hospital superintendent told me, "What this country needs most is a good depression to get the people back to work."

The Battle Will Go On

Unionization is an unfinished battle which, without doubt, will be fought with renewed vigor. Justice Pecora of the New York State supreme court is quoted as stating that strikes against hospitals are immoral, as well as illegal, but few doubt that we shall see more of them. Several hospitals have been subjected to picketing and other interference, while demands for increased pay and improved working conditions seem unending.

Some administrators feel that eventual unionization is inevitable but should be fended off as long as possible. The idea of having the conduct of hospital employes dictated by an outside person who has little understanding and less sympathy for hospital problems is abhorrent to all.

One of the changes forced by the war has been that some of the work done by each group of employes has been passed down to a lower group with less technical training. The added requirements have led to demands from each group for higher pay. It also made necessary a rewriting of job specifications, which is always a fertile source of discord. There is general expectation that both the quality and quantity of workers available will improve as demobilization progresses, but cessation of labor turbulence is not in sight.

Everybody agrees that the nursing staff has the most to do with establishing and maintaining the good reputation of the hospital, so the present shortage of nurses is a serious matter. In spite of the increased pay and the strong trend toward the forty hour week, the number of applicants for training as nurses is not enough to keep the ranks filled.

The marriage rate for nurses continues to rise and many of those discharged from the armed services are not returning to the profession. One director of nurses told me, early in 1942, "I am adopting the policy of employing only married nurses over 45. They are reliable and are free from the romantic antics of the young ones."

Now she says, "My mature nurses left me to become munitions workers. Those being let out by the army and navy have forgotten all the nursing they ever knew. Conditions are worse than they were during the war."

For a time the West Coast enjoyed a considerable advantage. Nurses who were married to servicemen went there when their husbands were headed out for duty in the Pacific and took jobs in hospitals while waiting for them. Now most of those husbands have returned, their wives have rejoined them and gone other places.

The administrator of a California hospital said, "I have letters from more than 50 nurses who want to come out here to work, but I know from experience that they are drifters, following the seasons. Before we could find out how reliable they were they would be on their way to somewhere else."

Many authorities look for an improvement in the supply of nurses after six months or so, believing that a large number will find it advantageous to return to the profession.

The shortage of doctors was as great as predicted, but now the pendulum has swung the other way and many areas are complaining of an excess. One hospital administrator complained, "We have more doctors on our staff than we have beds in the hospital." A number of institutions found it advisable to take on their staffs some physicians who were previously considered unsuitable for such privileges. The work of some of them was a cause for anxiety, but they are now firmly entrenched. Since the former members have been demobilized, many hospitals have the embarrassing problem of easing out the less desirable ones.

Doctors going to new areas say that they are finding it less difficult to obtain patients than to get an office, a telephone, a place to live and a hospital to which they can take their patients. Great as was the mass displacement of the public, with estimates running as high as 20,000,000 who moved, the migration of doctors was just as great in proportion to their numbers. Some areas are complaining of a scarcity while others feel that they have a surfeit. For instance, it is stated that 17,000 have applied for admission to practice in California.

What will the prospective requirements of the Veterans Administration mean to our voluntary hospitals? Maj. Gen. Paul R. Hawley brings it to our attention that if the future load of veteran patients were to be cared for in their own hospitals it would require a full time staff of 12,000 doctors, 40,000 nurses and thousands of other workers. He sees the need for a great amount of part time help, especially professional, and to get that the patients must be placed where such help is available—in large communities and the great medical centers of the country.

Teaching hospitals are to be preferred because it is conceded that they provide the highest standard of professional care. The present prospect is that the program will affect the hospitals in smaller communities only if arrangements are made to keep the veteran who is not too seriously ill in a hospital near his home. The agreement between the Veterans Administration and the Michigan Hospital Service is an excellent example of the shape that such agreements may take.

S. 191 a Topic of Interest

A topic of universal interest in the hospital world is the bill (S. 191) providing for hospital survey and construction, to relieve the shortage of beds which is felt almost everywhere. Will it pass? If so, in what form? What will it accomplish? The conference rooms buzz with these questions.

For the moment the bill seems bogged down in differences of opinion about details of administration and authority. Like Santa Claus, nobody wants to shoot it outright because there are so many nice things to be said about it. Inertia seems to be the greatest difficulty at present, and this can be just as fatal to legislation as the most glaring faults.

Fear is frequently expressed that government funds for hospitals will mean government domination of those accepting aid from this source. No one can doubt the danger of that sequence. One bill purposing to provide government aid to hospitals contains the proviso that no department or agency of the United States may exercise any supervision or control over any hospital which is not owned and operated by the United States. The presence of such a hedge clause serves better to emphasize the danger than to avert it.

As one administrator put it, "Whose bread I eat, his song I must sing. If I accept funds from the government, some day some person who has to do with the allotment of those funds is going to tell me to run my hospital a certain way or the funds will be reduced. Pretty soon he'll be dictating all the administrative details." It is something for all of us to think about.

The British Government has announced its intention to nationalize hospitals and medical practice. It is to be expected that this will be used as a lever to increase the pressure for compulsory medical and hospital plans under government control in this country. Unfortunately, those who oppose this trend have had no concrete plan until the American Medical Association recently announced its 14 point program.

Nearly everybody agrees that the public wants some form of medical and hospital insurance, but there seems to be no general conviction that the compulsory type is best. There appears to be a growing feeling that it would be more effective not to offer so much direct opposition to the movement, but to climb up into the driver's seat and steer it into safe and sane channels.

The general conclusion is that the wartime problems of the hospitals have been faced with courage and intelligence. As a result the evils have been less than was predicted. Nobody doubts that the war period saw a deterioration in the quality of service to the sick in our hospitals and the general disposition to acknowledge it is encouraging. There is universal determination to regain the old standards and even to surpass them, so the outlook for the future is bright.

Simplified Reports

Save Labor in the Laboratory

JOHN W. WILLIAMS, M.D.

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THE report forms and charts of 94 general and six specialized hospitals with censuses of 150 beds or more, picked at random in different sections of this country, are analyzed in the ensuing study. Practical methods for laboratory reporting are discussed and recommendations are made.

Dr. Malcolm T. MacEachern in his book "Hospital Organization and Management," recommended methods for standardization of laboratory reporting. He favored triplicate report forms, 5 inches wide by 3 inches long, of different colors to indicate type of examination; the original copy was a sticker form to be pasted on a full sized hospital history sheet provided for the purpose.

This original had glue on its upper ⅜ inch; the first report on the history sheet was pasted on the bottom of the page and successive reports were inserted ½ inch above so that types of examinations and dates could be seen and, when necessary, subsequent forms could be turned back to read the previous one. The copies were filed in the laboratory, one under type of examination and the other under the patient's name, arranged alphabetically.

Of the hospitals studied, 28 per cent use sticker forms. All methods suggested by Dr. MacEachern are used by 7 per cent, most of the principles, by 14 per cent and a few by an additional 7 per cent. Sixteen per cent of the hospitals use individual forms for each examination, about half of which may be pasted on a full sized history sheet. Four per cent of the hospitals use a full sized sheet, listing routine examinations and tests done on admission; if additional examinations are needed, another such sheet is used or entries are made on a sheet designated for additional examinations.

Sticker forms vary in size from 2 by 3 inches to 8½ by 5½ inches (half sized sheet). A popular size is 7 by 1 to 3½ inches. Several hospitals paste such forms in succession on the hospital sheet instead of overlapping them; one hospital uses different colors for positive and negative reports and reports which are not designated as positive or negative. Another hospital uses 4 by 3 inch forms of various colors which are pasted in two parallel rows on the history sheet.

Two hospitals use 4½ by 11 inch forms which can be pasted at their edge so that they overlap from the side; a number of hospitals paste other types of sticker forms so that they overlap from the side. Sticker forms may come as tablets or sheets, with or without serrated edges.

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Four hospitals make one or more carbon copies. For one carbon copy, a sheet 8½ by 10 inches, 5½ by 8½ inches, 6 by 9½ inches or 12 by 4 inches is used and folded over to receive the carbon.

A hospital may use 15 or more report forms for different types of routine examinations or it may use only one report form which serves also as a request form. An example of the complexity that report forms may reach is illustrated by one hospital which uses 14 report forms of seven sizes, four colors, three stickers, one with carbon, and one card.

Another hospital uses 12 sizes and shapes of white, or nearly white, report forms for different types of examinations. This complexity seems unrelated to the size of the hospital, its standing, whether it is or is not a university hospital and the section of the country.

Two Methods Opposed

Two methods used in recording laboratory results are not recommended. In the first, data are recorded on a history sheet used for other purposes, such as the history notes or the temperature-pulse-respiration form. Written into the history notes, the laboratory results may be difficult to find. On the temperature-pulse-respiration form, only a limited number of examinations may be recorded and in neither instance can the laboratory results easily be correlated. Reports from the laboratory by telephone or results of examination done by interns often are entered in the progress notes of the case.

Frequently, negative results are not recorded, making the case history of less value for reference. The laboratory should be given a section in the hospital chart and its data should be entered there and initialed as entered, in order that the one responsible may be consulted when necessary.

In the second method, single sheet reports are sent from the laboratory to the ward desk or main office of the hospital and may never be filed in the patient's chart. This may occur in a mass survey, for example, when all patients in a ward or institution are examined, especially by an outside laboratory, for hemolytic streptococci in their throats. This method of filing is inadvisable since the patient's record is likely to be incomplete and of less value as a reference.

Table 1 — Summary of Data on Master Sheets of 39 Hospitals

Type of Examination	Per Cent of Laboratories	Range of Dates	Average Dates
Urine	95	3-15	9
Blood	92	3-15	8
Blood chemistry	76	3-20	5
Bacteriology	38	2-23	6
Serology	51	2-20	3
Miscellaneous	60	4-40	19
Blood type	28	1-4	2
Renal function	36	1-40	4
Spinal fluid	51	2-9	4
Feces	46	2-8	4
Gastric	46	1-11	4
Sputum	25	1-9	5
BMR	23	1-5	3
Sedimentation rate	15	1-5	3
Surgical pathology	5	1-1	1
Skin tests	5	1-3	2
Body cavities	10	2-5	3

The most popular and best method of recording laboratory data, when used correctly, is the master sheet. Fifty-two per cent of hospitals studied use master sheets but some only to a limited extent or like a single report form.

The master sheet is a chart sized form listing type of examination with dates for entry of results. A hospital may use a master sheet for only one type of examination, such as urinalysis, or may list 20 or more types of examinations on the one form.

The master sheet may provide space under miscellaneous examinations for recording results on all types of examinations not designated. Entries on master sheets should be made daily in the ward charts on completion of examinations, preferably by a trained recording clerk from the laboratory. Reports from outside laboratories should be entered with the name of the laboratory that performs the examination.

A majority of laboratories use both sides of the master sheet. All data usually can be recorded on one sheet when this is done. Others prefer one side and several master sheets. Headings frequently used for types of examinations are urine, blood, blood chemistry, bacteriology, serology, cerebrospinal fluid, feces, gastric content, renal function tests, blood type, BMR and miscellaneous. Less frequently included are liver and other function tests, body fluids, skin tests, EKG and surgical pathology.

Table 1 summarizes material on master sheets of the 39 hospitals in which data were easily interpretable. The percentage listing the type of examination and the range of dates and the average number of dates given to the type of examination are recorded.

Discounting the heading "Miscellaneous" in table 1, the average number of types of examination listed is eight. Hospitals having largely chronic disease cases are likely to give more space to urine and blood; if the disease is cancer, more space may be given blood chemistry; if it is heart disease and rheumatic fever, to EKG and sedimentation rate, and if tuberculosis, to sputum.

Tables 2 and 3 are examples of parts of master forms. The lines of colons indicate that more spaces would be added for dates in a regular form (possibly corresponding to the averages listed in table 1). Table 3 is not as desirable as table 2, since dates and tests must be recorded both vertically and horizontally and not horizontally only as in table 2. In addition, entry of additional data in table 3 may be more difficult since the space allowed cannot be used as flexibly as that under "Remarks" in table 2.

May Be Listed Side by Side

Several types of examinations may be listed side by side when entry of the results of tests does not require enough room to take the entire horizontal space. Normal values and unusual tests are not included on master sheets since they complicate the sheet and make its reading more difficult. The nomenclature and tests given are those commonly used; as yet there has been no agreement as to standardization. In hospitals following a different procedure the master sheet would be revised accordingly.

When a hospital uses a standard master sheet and specialties call for a considerable number of specific types of examinations, such examinations can be printed in by the recording clerk with an appropriate number of date spaces allowed under the heading, "Miscellaneous Examinations." The caption, "Miscellaneous Examinations," need not be printed on the master sheet unless desired; additional types of often repeated examinations can be added in a similar fashion as they come

into use simply by changing examinations to be classified in the miscellaneous category to lower down on the sheet.

A hospital may prefer to list only two types of examinations, such as urine and blood, and print in the rest. After results are entered on the master sheet, the forms or sheets used for this purpose are filed in the laboratory.

Three Forms in One

Eight or more request forms for examinations, varying in color and in size from 2½ by 3 inches to a full sheet size, may be used by a hospital. Report forms may serve as request and charge forms, sufficient copies being made to meet all needs. Occasionally, the request, request-report or request-report-charge form is attached to specimen containers to identify them, but, more frequently, labels about 3 by 1 or 2 inches are used.

Patient admission cards sent to the laboratory on entry of the patient into the hospital may serve as notice to do routine examinations, other examinations being requested as desired. All requests for the day may come on sheets from the various subdivisions of the hospital.

Laboratories usually give examinations a file number, often with a prefix designating the type of examination. Examinations may be recorded in the laboratory on cards, on admission cards, on report sheets, in loose-leaf or bound book form or individually on report forms. Several methods may be used in one laboratory. Examinations, in addition to being recorded in the patient's chart, should be recorded under the patient's name, in an alphabetical arrangement, and under the type of examination. At the end of the month types of examinations should be summarized in a monthly report form and at the end of the year, in a yearly report form.

Reports filed in the laboratory should be readily available at all times under the patient's name. Monthly and yearly reports are important in administration and should be kept up to date. It is easier to look up the patient's name in a file and read off reports than it is to find the date (which usually is not remembered by the physician) of the examination in reports kept in books and then hunt for the patient's name

Table 2 — Example of Part of Master Form

JOHN DOE HOSPITAL

Laboratory Data

Name_____ Case No._____ Kahn Test_____ Blood Type_____ Rh_____

URINE EXAMINATION

Date	Col.	Reac.	Sp. Gr.	Prot.	Sug.	Acet.	WBC	RBC	Casts	Remarks

BLOOD EXAMINATION

Date	HB	RBC	WBC	Plat.	HMCR	Retic.	P	B	E	L	M	Remarks

SPINAL FLUID EXAMINATION

Date	Type	Prot.	Alb.	Glob.	Sug.	Kahn	Gold	Count	P	M	L	RC	Remarks

GASTRIC CONTENTS EXAMINATION

	Free HCl					Total acid				
Date	Stim.	Fast	10m	20m	30m	40m	Fast	10m	20m	30m	40m	Remarks

STOOL EXAMINATION

Date	Type	Col.	Oc. Bl.	Gr. Bl.	Pus	Muc.	Ova or Para	Remarks

BLOOD CHEMISTRY

Date	NPN	Prot.	Alb.	Sug.	CO_2	Chol.	Cl.	Sul.	I.I.

BACTERIOLOGICAL EXAMINATIONS

Date	Spec.	Remarks

MISCELLANEOUS EXAMINATIONS

Date	Exam.	Remarks

Table 3 — Example of Part of Master Form

JOHN DOE HOSPITAL

Laboratory Data

Name_____ Case No._____ Kahn Test_____ Blood Type_____ Rh_____

URINE EXAM.	Date	
	Col.	
	React.	
	Sp. Gr.	
	Prot.	
	Sug.	
	Acet.	
	WBC	
	RBC	
	Casts	

Date	Exam.	MISCELLANEOUS EXAMINATIONS

in order to find a report; in the latter instance the advantage of having all reports on a patient together also is sacrificed.

In some public hospitals physicians insist on having laboratory reports delivered to their desks. This necessitates individual report forms and the entry of the data on these in the history form usually is left to someone else and may be problematical. In such hospitals, also, in order to conserve space and because of difficulties which may arise if patients read their charts, histories often are filed in the ward office so that they can readily be pulled and only current TPR and patient note forms are kept in a looseleaf folder on the nurses' desk.

If this system prevails, laboratory reports should be entered directly from the laboratory into a looseleaf folder kept on the nurses' desk for ready reference of physicians. On completion of the case, these forms should be entered in the patient's chart.

Surgical pathology specimens come to the laboratory with a request form accompanying them. Most hospitals prefer a full sized report sheet. A few enter the data on the report of operation sheet. Copies retained by the laboratory usually are kept in book form. A patient's index and a tissue index are kept and the file number is entered in a diagnostic index under the appropriate diagnosis. Comparatively little difficulty is experienced with these reports. Other reports usually considered apart from clinical pathology reports are electrocardiogram, blood bank and donor.

Indented margins, colored margins and colored sheets often increase the ease with which laboratory and other reports can be referred to in charts. All laboratory results and entries should be initialed by those responsible for examination of the specimen or posting of results so as to establish a means of direct communication, should any question arise.

Suggested Plan

The following plan of handling the paper work of laboratory specimens is recommended as especially suitable for hospitals in which all laboratory work is handled from one office. It is flexible and can be adjusted to suit various conditions as they exist.

1. *Admission Card.* A 5 by 3 inch card is made out at the admitting office on each new patient entering the hospital. At the top of the card are entered such data as date, hospital number, name, age, sex, color, service and diagnosis. It is sent to the laboratory for the patient's file. This card is arranged alphabetically in the file. If certain examinations are routine, it is notice for their performance. On this card are listed, in sequence, briefed results of examinations done with date and file number.

These cards are kept on the work desk while the patient is in the hospital, readily available for laboratory and hospital staff reference, and constitute the active patient's file. When the patient leaves the hospital, his card is placed in the patient's inactive file. Should the listing of examinations done be required as a basis of reference for charge, these data should be collected from the card before it is placed in the inactive file.

2. *Request Form.* This, also, should serve as a report form and, if desired, as a charge form. It should be the same size as the admission card. If there are not more than five headings of types of examinations on the master form, it often is well to have a different color or shade for each type of examination; more than five colors would tend to confuse. For example, colored forms can be used for blood, blood chemistry, urine and serology and white forms for other examinations designated "miscellaneous."

3. *Specimen.* Every specimen sent to the laboratory should have a label of adequate size to give essential identifying data, *i.e.* name, hospital number and date; these data should correspond with that on the request form.

4. *Recording Results.* The person responsible for the examination should record and initial the results on the request report form. The recorder should collect these forms and enter and initial the results on the master sheet of the patient's chart at the end of each work day.

Types of examinations for the work period should be added up and entered in a ledger to be used in computing the monthly and yearly work load of the laboratory. The request-report sheets should then be filed in numerical sequence in the "type of examination" file. In instances where examinations are done by another laboratory, a notation should be made. Another file will be necessary for these report slips.

Conclusions and Summary

The complexity of laboratory reporting does not appear to be an index of the merit of a hospital. It does, however, indicate work done and the magnitude of potential sources of confusion.

The preferable form on which to record results of laboratory examinations for the patient's history is the master form. Less space is taken up, the physician has all examinations before him, the difficulty of pasting does not exist, examinations are placed under separate categories and the inconvenience of lifting slips and of their becoming wrinkled and difficult to handle is obviated. If sticker forms are used, thin strips which can be pasted one below the other without overlapping are preferable.

One person should be given the responsibility of recording results. Such a recorder, also, should be in charge of laboratory files. It might also be possible to add the duties of allocation of specimens and the morning collection of such specimens as those for serology and blood chemistry; when the collection of these is the responsibility of the laboratory much confusion is obviated.

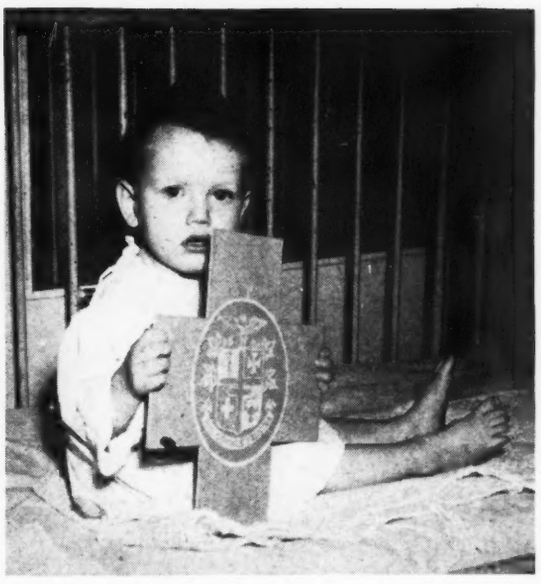
The suggested plan for handling paper work should be adaptable to most hospitals. Clinical pathology should be handled through one office if possible. Often it cannot be because of the physical plant, in which case methods have to be worked out accordingly.

While small hospitals may not be able to incorporate some of the suggestions made, the data discussed should be valuable. Also, other administrative systems in some hospitals might have to be changed or standardized before changes could be made in laboratory reporting. Methods followed in hospital clinics might interfere.

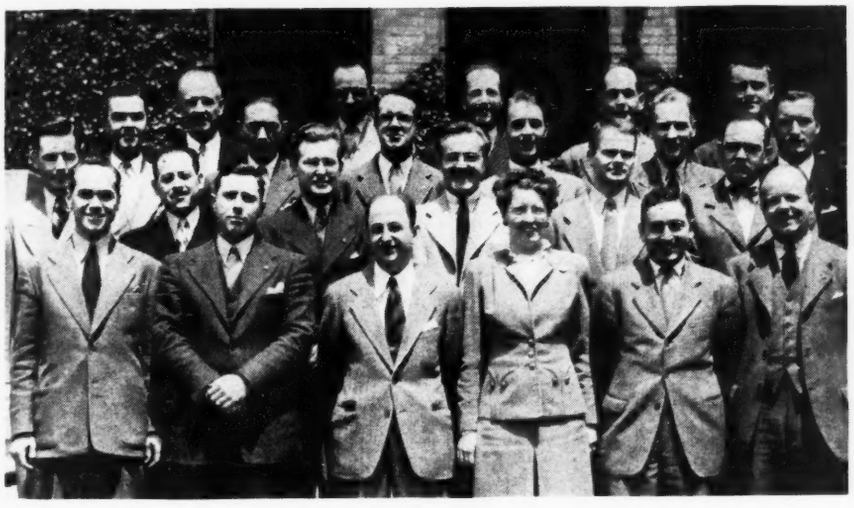
It is felt, however, that the principles stressed are the most practical and can be adopted to advantage in part or in whole by hospitals that are experiencing difficulties or are being snowed under by heterogeneous and diversified slips of paper.

PEOPLE IN PICTURES

Elmer Paul and Elizabeth Jane Davis receive Malcolm T. MacEachern medals from George A. Kellogg of Johnson and Johnson Research Foundation as top ranking graduates of Northwestern University course in hospital administration. Looking on are Prof. Myron H. Umbreit and Dr. MacEachern, director.



Lawrence Walsh, 19 month old resident of Philadelphia, gazes reflectively over the Blue Cross which symbolizes his claim to fame as the 300,000th person to be hospitalized by the Associated Hospital Service of Philadelphia.



Hospital administration class at Columbia-Presbyterian Medical Center. Left to right, first row: Robert Anderson, John Martin, Dr. Jacob Horowitz, Mary Johnson, Irving Gottsegen, Carroll Hill; second row: Charles Stewart, Dr. Salvador Hernandez, John Moulton, Harry Gifford, Howard Taylor, Dr. James Dixon; third row: George Cartmell, Charles Berry, Gerhard Krembs, DeForest Whipple, Dr. Turner, John Kolody; fourth row: Dr. August Groeschel, Frederick Wood, Peter Scott, Dr. Robert Lowe, Arthur Burns. Two other class members, not shown, are John Tiernan and Miss Ross.

H. J. Mohler, president, Missouri Pacific Hospital Association, received the annual St. Louis Hospital Council Community Service Award for 1946. It was presented to him by Florence King, superintendent, Jewish Hospital and chairman of the council's publicity committee (at Mr. Mohler's left). Other members of the presentation ceremony, from left to right, are: Ila Lee Mohler, Mrs. Ray F. McCarthy, Mrs. Mary J. Keith, treasurer, F. W. Russe, trustee, St. Luke's Hospital, and Mrs. H. J. Mohler.

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to the demand for more medical record librarians

ETHEL BILES
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"IN-SERVICE training is imperative for continued development of the medical record librarian profession because training schools cannot meet the demands for record personnel and because hospital admissions are increasing and will continue to increase and large numbers of trained medical record librarians are needed to handle this increase."

The foregoing statement was made by Dr. M. G. Westmorland in the December 1945 issue of the *Journal of the American Association of Medical Record Librarians.*

2000 Charts Incomplete

Looking back on the last week in January of 1944 it seems incredible that one of sane mind and able body, with five years' hospital experience in the business office but none in medical records, could walk into the office of an administrator and not only ask, but campaign for and win, the opportunity of becoming the medical record librarian in a 500 bed hospital. In this medical library there were more than 2000 incompleted charts; approximately 7000 charts needed cross-indexing. Charts literally covered the desks, the window sills and every available chair and stool!

The personnel was near nervous collapse from the constant strain of digging for charts. Practically all employe time was consumed by this process so that each day added to the stack instead of diminishing it.

Do not accuse the administrator of poor management for hiring an untrained person. The work had to be done; an adequately trained librarian was unavailable; in-service training was the only solution.

In the beginning these three problems were apparent: (1) more working space for the overcrowded office was needed; (2) all procedures were to be learned; (3) back work was to be completed.

Space other than that already occupied by the department was absolutely unavailable; therefore rearrangement was the order of the day. For a few weeks we noted what files were most frequently referred to and those seldom used were moved to our storage room. More floor space was made by replacing a large desk with a typing stand. One clerk spent all day typing so this stand was made large enough for her work.

The incompleted charts were rearranged in alphabetical order for quicker reference. All of this rearranging was done after regular working hours. The straightened appearance of the room made the everyday routine much simpler. Strained looks began to disappear.

For several months this overtime work was routine for the new librarian but the personnel was asked to take turns working evenings with her. Working with each girl individually was a short cut to learning the procedures; it also enabled the librarian to determine the position each girl was best qualified to fill.

During this period Dr. Malcolm T. MacEachern's "Medical Records in the Hospital" and Mrs. Edna Huffman's "Manual for Medical Record Librarians" were constant companions. Norah Smith, R.R.L., the record librarian for years at Parkland Hospital, Dallas, Tex., was most helpful; her advice was indispensable.

Here we might pause long enough to say that at all times the administrator was conscious of the importance of good medical records and 100 per cent behind any changes or plans that could be proved to be of value to the institution. Without an administrator of this kind the record librarian is lost before she begins.

Dr. Thomas R. Ponton attended our Texas Hospital Association meeting at this time and suggested that a good way of forestalling any future recurrence of mass incompletion of charts was to withhold the interns' and residents' checks each month until their charts were completed. This we have found to be a highly practical plan. To date no such "disaster" has recurred.

Attends Staff Meetings

Our department attends the monthly staff meetings, serving at the registration desk and taking calls for all doctors attending the meetings. This affords an opportunity of knowing the doctors and promotes better working relationships. The programs are a vital part of our in-service training.

The Dallas chapter of Medical Record Librarians meets once monthly at a centrally located cafeteria for dinner and a combined business and study session. For the programs specialists in each field of medicine from the staffs of the various hospitals rotate in giving instruction and explaining any procedures in question.

The business session is our "problem exchange." Here individual worries are brought into proper focus by comparison with those of other hospitals. Many a worry vanishes when we find either a solution to our problems or a working knowledge of them.

The most concentrated and outstanding training period of the last

two years was the week of May 12, 1945, in Chicago. This was the week of the institute for medical record librarians sponsored by the American Hospital Association. Here the counsel and teaching of veterans in the field made short work of problems past, present and future. Every hospital administrator should be more than willing to send his librarian to such an institute yearly, expenses paid. The benefits derived will far outlast the expense incurred. Plans are now in the final stages for a medical record librarians' institute to be held in Dallas the week of December 2.

Checking with two universities and several business colleges located in Dallas, we found that no course in medical terminology or medical dictation was offered in this city which contains a medical school, 17 hospitals and approximately 625 doctors belonging to the Dallas County Medical Society. Baylor University Hospital has taken steps to inaugurate such courses.

Approves Recommendation

Our first effort in this direction is the institution of a trial course on the hospital campus. The following recommendation was submitted to the administrative council and approved by it.

"Recommendation to the administrative council of Baylor University Hospital: Being fully cognizant of the acute shortage of medically trained office personnel, and the expense unduly attached to its training, we deem it expedient and to the best interests of all departments requiring personnel trained in the use of medical terminology to institute our own training program. In conformity with this idea we submit the following general suggestions:

"1. That a six weeks' trial course be instituted immediately.

"2. That this course be taught at the hospital on Tuesdays and Thursdays from 4:30 until 5:30 p.m.

"3. That a teacher be obtained from the nursing school and that she be given an honorarium for this service (this to be paid by the hospital).

"4. That each department head sending employes to the class submit a list of medical terms most commonly used in the department so that the course will be concise and attuned to immediate need."

GARDEN THERAPY

another step on the road to rehabilitation

MRS. HAROLD PLIMPTON

Hospital Horticultural Service Committee, National Council of Garden Clubs
Chestnut Hill, Mass.

USING the known and accepted fact of the therapeutic value of gardens and flowers, horticultural therapy has been considerably developed by doctors and nurses as one phase of the rehabilitation program in the service hospitals.

Here in Massachusetts this work has been aided by Garden Clubs Service, a volunteer group representing some 8300 Massachusetts women. Their contribution has been to supply flowers weekly in 20 hospitals and infirmaries, to donate special decorations at Thanksgiving, Christmas and Easter and to furnish materials, tools and help in gardens for patients. Two sunheated pits and a small greenhouse have made possible, at three hospitals, continuation of the gardening program throughout the year.

This service developed from a small beginning before Pearl Harbor. Through the many changes during the war and since its end, the closing of certain hospitals and the enlarging of others, garden club women have continued this work, adjusting their service to the needs and to the wishes of commanding officers. With the growth of veterans' hospitals, the future of Garden Clubs Service would seem to lie for the most part in those fields.

Far from being Lady Bountifuls, the garden club women prefer to act from back stage. Their rôle is to raise the necessary funds (the 1946 budget is $15,000) to supply the materials and to help in any way possible in furthering this work. When gardens are asked for at a hospital, garden club women are available for planning and starting the project, but the true value to the patients is in actual garden work rather than in mere enjoyment of a beauty spot. For this reason the gardens must be part of the rehabilitation program or they fail of their purpose.

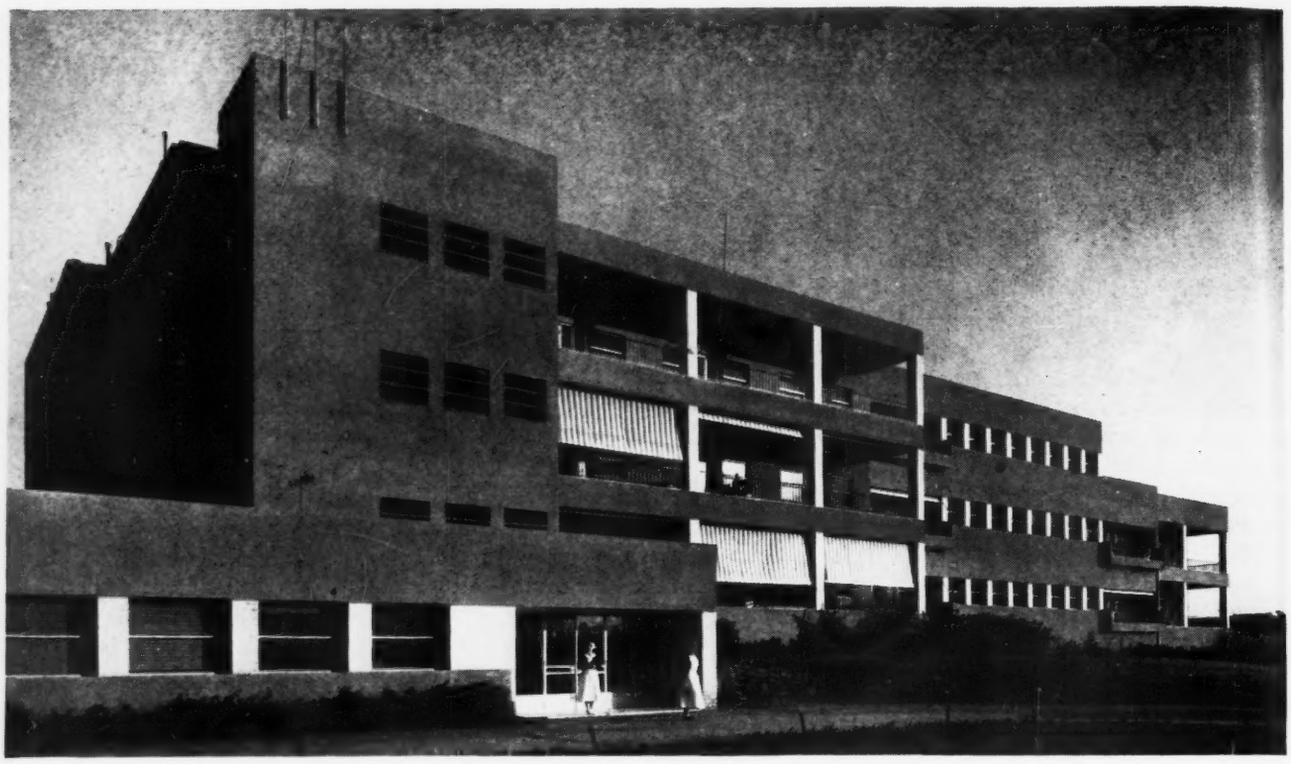
At Camp Edwards a garden of some 3 acres was asked for and supplied. Here the men learned and practiced the rudiments of gardening: cultivating, planting, transplanting, pruning and grafting. At Lovell General Hospital, the growing of seedlings under glass has been part of a therapy program, as has the winter work in the sunheated pits at Cushing General Hospital and at the Chelsea Naval Hospital.

The potentialities of this sort of therapy are many and have not been fully developed, but Garden Clubs Service stands ready to do its part in making them possible.

Program Goes on in Winter

Not only have flowers brought in weekly to the wards played their part from an esthetic point of view but also this service has answered that need known as "patient anticipation," the something to look forward to regularly and with pleasure. All through the year the flower service is carried on, in the summer with garden flowers and in the winter with flowers bought from florists, arranged by garden club workers and carried to the wards either by these women or, where hospital regulations make this impossible, by Gray Ladies.

The garden clubs throughout the country have done similar work, differing from state to state as conditions demand. I write especially about Massachusetts since here the work has been highly organized and developed. But the latent energy and willingness to cooperate are to be found wherever garden club women are, and much more of this service could be asked for and supplied if hospital administrators, doctors and nurses saw the need for it.



BEILINSON HOSPITAL NEAR TEL AVIV

Health Service Works in Palestine

THE Workmen's Sick Fund of the Jewish Federation of Labor in Palestine combines the voluntary spirit and organization of our Blue Cross plans with the full scale health coverage envisioned by the sponsors of a tax supported national health program.

Through its own hospitals and clinics and their staffs, the fund provides members with complete medical, hospital, nursing, dental and sanitary service. The same organization also provides sick benefits for workers, unemployment and survivors' insurance, old age benefits and relief funds.

The Jewish Federation of Labor has 300,000 members, or nearly half the Jewish population of Palestine. All workers in the federation participate in the sick fund and other social security benefits.

About 80 per cent of the fund's annual income comes from workers' contributions. The other 20 per cent is contributed by employers, but, according to Dr. H. Heller, medical superintendent of the fund's Beilinson Hospital, half the employers' contributions come from projects which the federation itself manages. In 1945, 0.04 per cent of the fund's $6,000,000 budget was contributed by the government.

On a recent trip to this country to study hospital design and technics, Dr. Heller explained the fund's origin. It was founded 30 years ago

Typical of the rural outpatient dispensaries that form an essential part of the health service is this structure at Kfar Saba.

to provide medical service and sick benefits for agricultural workers. Then, as the early cooperative agricultural settlements grew into villages and towns, industrial, clerical and professional workers were added to the membership.

Members' contributions to the fund are on a percentage of income rather than a fixed fee basis, with lower income groups contributing from 3 to 5 per cent of income annually for the full medical and social security benefits the fund provides. All members and their families are entitled to exactly the same services, regardless of the amount of their individual contributions.

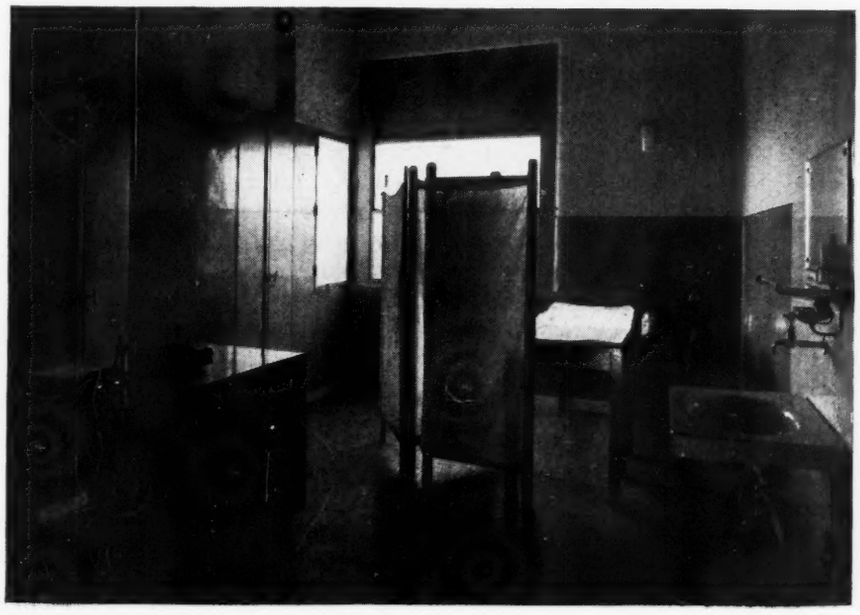
Medical care is rendered through a system of dispensaries or health centers, clinics and hospitals, similar to the system which the U. S. Public Health Service has proposed for rural areas in the United States. The 175 dispensaries are widely distributed across the country; no hamlet, village or collective agricultural settlement is without one. Here the doctor sees most of his patients, carries on the bulk of his routine practice.

Doctors are all full time salaried employes of the fund, Dr. Heller emphasized. The average doctor's salary is from $3000 to $4000 a year, twice what skilled workers earn today in Palestine and about 30 per cent more than other professions, such as engineering, are paid.

Complicated cases are referred by the dispensary doctors to larger, more centrally located clinics where full diagnostic and treatment facilities are available. In the early days of the fund, members used public or government hospitals. However, these proved to be inadequate, and in 1930 the fund built the first of its own hospitals. Today five fund hospitals totaling 400 beds care for many member patients, although many still use public hospital facilities with the fund paying the full bill. About one third of the beds in public hospitals are filled with fund members.

Beilinson Hospital near Tel Aviv, with 190 beds, is the largest and most modern of the federation's institu-

Above: Convalescent patients enjoy the terrace at Beilinson Hospital. Below: A ward in one of the five hospitals built by the Workmen's Fund.



The greater part of the doctors' routine practice is carried on in offices, such as this one, in the 175 outpatient dispensaries.

tions. Present plans call for a new 400 bed building which will make this a complete, modern medical center.

Some of the advantages of complete medical and preventive care for an entire population are apparent from a comparison of medical experience in Palestine and the United States. For example:

"Even in the fairly large hospitals like ours, we never see the complications following appendicitis which are fairly common in your country, judging from my visits to hospitals here and from the medical literature," Dr. Heller observed. "You see, there is no possible reason for any person with symptoms to stay away from the doctor, who is quickly available and whose services are already paid for. Then, if the doctor has any cause to suspect serious illness, he will always send the patient on to the hospital. Again, there is no reason not to do so."

Condition Is Improved

With full preventive service freely provided, medical examinations for the well, in addition to the sick, population are routine, with consequent improved results in the treatment of conditions which must be diagnosed early. For example, Dr. Heller rarely sees a case of diabetic coma; all diabetic patients are known to the doctors in their communities, and regular checkups are made to see that proper care is given them.

One hundred per cent of sick fund mothers have their babies in the hospital, Dr. Heller reported, with resulting salutary effects on infant and maternal mortality.

All doctors, it was emphasized, attend weekly staff conferences at the clinic or hospital. *All* errors of diagnosis are known and fully discussed. Necropsy ratios in fund hospitals approach 100 per cent.

"Of course," Dr. Heller acknowledged, "with a small, compact population we can do many things that could never be accomplished in a huge country like the United States. That is plain. Furthermore, there is no questioning the fact that America leads the world in medicine today. The best in American medicine is the best there is.

"But our *average* standards are higher than yours. Our best is not as good as yours. Our peaks are lower. But we have no valleys."

Another Problem of Peace

The Revolt Against Routine

JOHN F. CRANE
Assistant Director, Montefiore Hospital, New York City

A MINORITY of people has always sought newer and more successful ways of circumventing and breaking rules. One gets the impression during these postwar days, especially in hospitals, that this minority is gaining new strength, perhaps because of our enemies. The revolt against routine seems to be in full swing. Nor is it confined entirely to workers in the lower brackets.

My colleagues fret and fume about this development but they seem to be helpless in the prevalence of disorder. They give me the impression, at times, that they consider it a waste of effort to post notices and to issue corrective orders. A few examples will illustrate the point.

"No Smoking!" They Smoke

A general order is posted at strategic points throughout the hospital setting forth various locations, such as waiting rooms, recreation rooms and lavatories, where smoking is permitted; this is an important administrative procedure. In this order it is also specified that smoking is not permitted on certain other locations, such as the wards, corridors and other designated places. In a comparatively short time we find patients and employes violating this rule, the most frequent excuse being that if it is all right for the doctors to break such rules, then there is no valid reason for others to observe them. This is logical reasoning and, in such cases, the fault must be shared by the visiting or house staff member who should know better.

I was also told of a porter who was arrested in another hospital for attempting to dispose of a flushometer which he had obviously stolen from that hospital. He gave as his excuse that the fixture was the property of an outside contractor and that it was therefore no concern of the hospital, forgetting that the basic fact of his dishonesty was of paramount importance. His arrest and conviction, for which we must be grateful to the authorities of that hospital, did no doubt have a salutary effect on those who might share his opinions about property rights anywhere.

Visitors Rebel, Too

In a hospital that cares for patients with a communicable disease there is a common sense rule that children are not permitted to enter the hospital or its grounds, yet relatives who cannot control their "mother complexes," "father complexes" and the like arrange for children to be lifted over the iron fence to be embraced by the family. In our sympathetic response to such situations, we may be inclined to turn our backs on such incidents. As guardians of the public health, however, we must enforce such a rule rigidly.

There are good administrative reasons for insisting that all hospital employes leave via the main entrance, yet we too often see employes leaving the hospital by other ways, as if to flaunt their revolt against routine. The psychology of discipline is apparently different in times of prolonged peace, in wartime and in postwar periods.

We have been learning these basic facts in thousands of ways during the course of our daily routines in hospitals during the last decade and must find a way to deal with them in the best interests of our patients.

LESSONS in LABOR RELATIONS

ARTHUR C. BACHMEYER, M.D.

NELLIE GORGAS

ALDEN B. MILLS

HOSPITALS that consistently and effectively pursue the personnel practices that have been found most effective in progressive industries are most likely to be rewarded by having loyal and contented staffs which will probably feel little need for a labor organization. These practices and their application in hospitals are summed up briefly in the following paragraphs.

1 **PLACEMENT:** In many hospitals, there has been an earnest effort to make thorough job analyses covering the work content of each job, the type of work involved, the training necessary, the personal characteristics that are preferable, the physical conditions under which the work is to be done and as much other information as can be obtained to complete the picture of the job.

After the trained analyst has reviewed each position, job specifications have been prepared and cards have been written to make a permanent record of the data for use in determining exactly what the "hole" is which has to be filled and, as accurately as possible therefrom, what type of "peg" is needed to fill it.

A personnel officer, who devotes either full or part time to this function, is becoming more commonly found in hospitals, particularly the larger ones, keeping these records up to date and using them to help in the selection of the proper person for the job. Final selection usually is made by, or in consultation with, the department head concerned.

Included as a part of this procedure is the use of aptitude or proficiency tests but not much has been developed yet in this regard in the hospital field, except for certain of the more highly skilled positions. Aptitude tests for girls hoping to enter nursing are well established now as are tests for clerical proficiency. Before the war personnel workers were developing more such tools to help in the selection of workers.

Probably one of the most important criteria used is, "What has the applicant done?" Obtaining his own opinion and that of others as to how he demonstrates the qualities needed in the job he seeks, *i.e.* perseverance, ingenuity, quick-wittedness, clear-sightedness, tact and diplomacy, is more effective than any test thus far in use in either industry or the hospital.

2 **TRAINING PROGRAMS:** Training of professional employes is, of course, well regulated in the hospital. That is, the nurses' and interns' education, as well as that of apprentices in the laboratories and other departments, has long been an integral part of the hospitals' program. More recently, the Training Within Industry program has been installed in many hospitals to help in the training of unskilled workers who until recently have often learned only by "watching Joe do it," without adequate explanation.

3 **MERIT EVALUATIONS:** These are not as regularly employed in hospitals as they might be. In most institutions, it has been felt to be too heavy a task to rate and record the employes' merit except in the nursing department, where the staff is more or less accustomed to working along educational lines and making frequent reports.

When there are time and labor enough to keep these records up to date and to make reports at least quarterly, they are valuable because, when filled out correctly and honestly, they provide concrete evidence of the work performance of the employe. There is much that should and could be done in this regard in the way of educating both the department head and the worker to use merit evaluations not only as an indication of how well the department head has selected and trained and how well the worker has adjusted himself but also as a means of correcting delinquencies and deficiencies early.

The modern concept of merit evaluation plans regards them as designed primarily to help the worker improve his own ability and effectiveness. Thus, the rater and the "ratee" talk over the evaluation periodically to recognize good work and to correct poor habits and attitudes.

4 **SENIORITY:** While seniority is generally accepted as a desirable consideration for promotions, hospitals do not always follow it and promote the person who has been in the job the longest because it is particularly important to have exactly the right type of skill and personality for each job in the hospital. More attention, therefore, is generally paid to the qualifications of the worker than to his length of service.

Ability, personality, attitude and length of service, in the order named, have proved most satisfactory. Length of service should be the determining factor in filling a position when the other qualifications of applicants are equal, but in every instance it should receive some consideration.

5 **DISCHARGES:** Control of discharge is entirely in the hands of the administrator and his department heads, but more attention should be paid to the discharge procedure. While there are times when continuation of service cannot be tolerated because of the influence one employe may have upon others or because of actual hazard to patients, usually two weeks' notice is given after the employe has been admonished several times and warned definitely at least once by the department head.

Exit interviews should be given when possible, so that the personnel manager may have a final opportunity to find out whether the maladjustment is due to any correctable factor. As a general rule, the employe in the hospital has a feeling of assurance of tenure and continuity of employment if his service is at all satisfactory. Hospitals for the most part, partly as a result of their altruistic philosophy, have been more than tolerant in handling their employes.

6 **WAGES:** It is recognized by hospital administrators and trustees that the worker is entitled to receive wages that are as high as those generally prevailing in the local hospital field and approximating those paid for similar work in other fields. Due consideration must be given to the fair current value of maintenance and other perquisites received, such as uniforms, vacations, sick leave, medical care, hospital care, annuities, life insurance and retirement allowances.

The desirability of paying a straight cash salary without maintenance so that workers can maintain their independence and know exactly how much their total salary is in comparison with that of other workers needs careful consideration. Few workers think the matter through clearly enough to realize just how much more than their cash stipend they do receive. Few value the maintenance they receive at what they would have to pay for it elsewhere.

A definite salary schedule has been put into effect in some hospitals, often based on detailed job analyses. A schedule is desirable although, in periods of rapid change in economic conditions, care must be taken to keep it up to date. In the industrial and commercial fields recent federal rulings with regard to wage increases have given the advantage to organizations in which there are regular salary schedules and systematic salary increase plans in force.

7 **HOURS OF WORK:** A gradual reduction in work hours per week has been taking place in recent years. Nurses, for the most part, are on a forty-eight hour week schedule although the present shortage of nurses may make it imperative in some areas that longer hours be served. But every effort is being made to adjust the hours into more normal periods.

In the kitchens and on the nursing units, straight shifts are the objective and, whenever possible, schedules are being arranged that way. Here, too, hospitals are rather hard pressed by the shortages of labor and may not be able to continue the improvement made in the past few years.

The six day week is another fairly recent achievement which it is hoped hospitals will be able to continue. State laws in some cases limit the number of hours an individual may work but it is an objective which hospital administrators are striving to achieve voluntarily.

8 **VACATIONS:** Vacations with pay are now the established custom for practically all hospital workers. They are now commonly regarded as an "earned right," not a special favor, as they used to be considered. Vacations in the hospital compare closely to those in other fields and are more generous in some cases, again in accord with the more generous policy in the way of perquisites which hospitals have developed, recognizing the great strain of hospital work and the importance of maintaining stability. In the hospital, they usually vary in length with position and tenure of office.

9 **HOLIDAYS:** These, too, are becoming accepted by hospitals as something due all employes. Legal holidays (up to six, eight or more per year, according to state custom) are now granted as full days in most institutions, although it is difficult to schedule these extra days off duty and maintain a staff sufficient to cover the work. While it is difficult for the department heads to provide for these absences and to carry the work with depleted staff, they are doing it even with help as short as it is. Of course, many of the workers have to take some time other than the actual holiday off so as to cover the service.

10 **SECURITY:** Hospital employment is not seasonal. A full staff has to be maintained day in and day out, month after month, so the satisfactory worker is usually quite sure of year around employment. This is one of the most important advantages of work in the hospital.

Hospitals are not yet protected by participation in federal social security programs since charitable or educational institutions are excluded from such coverage. This places a moral responsibility upon the hospital to care for its own employes and to meet the competition for workers from other fields in which social security protection is provided.

A few institutions have established retirement allowances but in most instances hospitals, if they have done anything at all, have pensioned workers on the basis of their particular needs at the time they were no longer able to carry on their work. More hospitals have done something with regard to life insurance through group schemes that provide death benefits sufficient to pay funeral expenses and give some relief to the immediate needs of the family.

11 **WORKMEN'S COMPENSATION:** This is required of hospitals wherever it is required of other enterprises, but there is still one state that does not require it by statute. Some states allow self insurance with the provision that compensation be as liberal as with an outside insurance coverage. Occupational diseases are included in many states, thus affording protection for employes who are exposed to serious health hazards. The cost to the hospital is not prohibitive and the plan is of benefit.

12 **HEALTH INSURANCE:** Sickness prevention and protection have been provided by the voluntary hospitals wherever possible as a part of their program for the community. Many hospitals have always provided medical care and hospitalization without charge for all employes in case of illness, sometimes even for their families. This, however, has been considered by some

as a form of paternalism that is not universally desired. The modern worker often prefers to pay his own way. He would rather have as large a straight cash salary as possible and make his own plans for living.

Many group plans for hospital care have been instituted and in many cases the Blue Cross plans have provided a solution of the problem for the hospital employes. The employe usually wants the privilege, however, of selecting his own method of protection. Many hospitals require that he accept responsibility for himself if he does not join the plan that they are using for their employes. Health service for employes, including examinations, advice and treatment, has been instituted in many organizations.

13 **PHYSICAL FACILITIES:** Physical surroundings and environment are influential in maintaining employe morale. Sufficient locker space, restrooms and pleasant dining rooms are recognized as important. If maintenance is provided, the effort should be to make living conditions desirable, with adequate common rooms and plumbing.

It is recognized that the more normal the existence of workers, the better will be their services in the hospital. A normal home life away from the hospital is most desirable, but if the employe must live in the hospital he should be made comfortable. Recreation facilities have been provided and their use has been encouraged in many cases. Some hospitals still fall short of desirable minimum standards in regard to employe living accommodations.

This is the second in a series of three articles on personnel practices. The concluding section will be published in the September issue.

Without Friendship

There is no real service

THE most expressive and yet the simplest definition of social service is friendship. Frequently, the interpretation of social service is that it ministers only to the needs of the poor. This is not true. I have found that none is exempt from the need of friendship at some time or other and the work of social service extends far beyond the poor. For who is poorer than the poor in spirit?

Social Workers Made Her Sick

In this connection, one incident is noteworthy. A woman rushed into the office one day and irately exclaimed, "Oh, these social workers make me sick!" I looked up to find a woman I had never seen before, angry and defiant. For a moment, I didn't know what to say, but I realized that the first thing to do was to restore her to a calm state of mind. I said, "Yes, social workers are a pest, aren't they?"

Instead of the argument she expected, I had agreed with her. I invited her to sit down and she proceeded to tell me of more or less imaginary wrongs which she felt she had suffered at the hands of some other social service department. After a thorough discussion and analysis of her problem, she left with an entirely different point of view saying, "Oh! it is wonderful to find an understanding friend." She did not realize that this is the usual occurrence in the social service department.

Humor and pathos which appear so often in the social service department are well illustrated by the following incidents.

A few years ago a mother of nine children was brought to the hospital and in a few hours passed away. Naturally, the social service was directed to care for the children and the home, since the father was anxious to keep his little family together. I made frequent visits and took food and clothing.

One day, about three months after the death of his wife, as I left the home, I heard the husband's voice call out, "Wait, Miss." Approaching the car with a smile and a gleam in his eye, he edged near, saying, "You know, I don't miss the Mrs. any more!" Having a premonition of more to follow, I beat a hasty retreat. I had the feeling that I had narrowly escaped a proposal—of course, as caretaker for the children! A few weeks later this man married a widow with seven children and apparently they lived happily ever after.

A visit was made to an old man who had been a patient in the hospital. His home consisted of one room and a small lean-to used as a kitchen. The man seemed to have taken stock of his years and in a philosophical way had prepared for his last journey. He asked me if I had a few minutes to spare and proceeded to draw a large box from under his bed. The box contained a suit of clothing, a white shirt, shoes and other clothing which he said his clergyman had given him. He said, "You know, I have no relatives and when I pass away I want to be dressed properly." Then, following a moment's hesitation, he asked earnestly, "D'ye think I'll need me derby?"

It Is True Friendship

Yes, I feel that social service under the name of Friendship would cause less confusion in regard to its function. For when all is said and done, it is understanding and applied friendship. Kind hearts and true friends are God's best gifts.

—MARY H. LAVINE, R.N., *director, social service, Nassau Hospital, Mineola, N. Y.*

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SMALL HOSPITAL FORUM

Watch Those Medical Records

Doctors need jacking up if records are to be kept up to date and staff performance at par

MAINTENANCE of adequate medical records on patients is a continuing problem in small hospitals, answers to a Small Hospital Forum on medical staff problems indicate. Only two of 17 hospitals participating in the forum on this subject are able to give an unqualified "No" in reply to the question, "Is the medical staff of your hospital careless about writing up patients' histories and keeping records up to date?"

Laggards Are Worrisome

Several hospitals indicate that staff members for the most part are conscientious about keeping records up to date, but a few laggards on the staff remain a worrisome problem. Here are some typical replies from this group:

"The question cannot be answered with either 'yes' or 'no.' The majority of the physicians complete their records while the patient is still in the hospital."

"Now and then, doctors must be jacked up for not signing completed records."

"Most of them do keep their records up to date."

"The doctors have been very busy during the war and have not been able to do as well as we should like them to do. We have more clerical help now, and a dictating machine, which is helping a great deal."

"They are busy and must be reminded frequently to complete records for filing."

"They have been careless until recently. Since our men have returned from the service the whole group has been much better, probably because it is not quite so busy now and the records committee is more alert."

"We have a full time medical record librarian with an assistant record clerk working constantly with the doctors, so we are able to keep our patient histories up to date. Our record librarian writes patients' personal histories, with the doctor giving the results of the clinical examination."

Seven hospitals, or more than 40 per cent of the participating group, indicate simply that the staff is careless about records.

Six of the reporting hospitals do not have any trouble getting staff members to file a provisional diagnosis at the time of a patient's admission and a corrected diagnosis before discharge. The remaining hospitals in the group have some difficulty keeping the records up to standard in this respect. Five hospitals report simply that the problem exists, without indicating its nature. Three acknowledge that the chief problem is to get a provisional diagnosis for every patient admitted. One administrator writes that it is hard to complete the record with a final diagnosis "within a reasonable time."

Diagnosis on Admission

"We have some trouble, but not a great deal," another hospital replies. "When a patient is admitted we insist on the attending physician's making a diagnosis. However, like a great many other hospitals, we have our difficulties on this subject. At present, owing to crowded hospital conditions, a physician will perform his duties well in order to keep his record clear so that he will be able to get accommodations for his next patient."

The reporting hospitals divide about evenly on the question of attendance at staff conferences. Seven hospitals state that there is no negligence on the part of staff members.

"We have more physicians wanting to attend staff meetings than we have room to accommodate them," one hospital in this group explains. "We serve a light lunch, insist upon running absolutely on schedule and have very good equipment for slides and moving pictures. The physicians are extremely enthusiastic."

Staff Meetings Well Attended

Among those reporting carelessness about attendance at staff meetings on the part of attending physicians, the majority indicate that most doctors attend faithfully, but a few are errant and have to be "kept after." On the whole, the replies show that staff conferences are scheduled and attended in accordance with accepted standards.

Several methods are suggested for improving staff performance in these various details when carelessness becomes widespread enough to demand action. About half the hospitals reporting remedial procedures keep these matters at the administrator-staff level. In a few cases action by staff committees is sufficient to produce satisfactory results. Other reports are less encouraging:

"The administrator gets after the staff officers and they, in turn, get after the other men," one report reads, "but it needs eternal vigilance."

"Administrator has tried to get cooperation," another says, "but staff members always seem too busy to attend meetings."

More encouraging are the results achieved when staff problems are made the concern of the governing board:

"Trustees have authorized the director to deprive staff members of all hospital privileges if they fail to keep their records properly," one reply states. "This rule seldom has to be invoked."

"All staff problems are referred to the board of trustees in the form of resolutions for approval or disapproval," another hospital administrator explains. "When staff members become too careless concerning their records, it is reported to the board by the superintendent and the board, in turn, writes the staff member telling him of his delinquency. To date, this method has proved satisfactory."

Still another hospital reports that this general procedure is followed:

1. Supervisors and nurses continually remind staff physicians that histories are to be written and records kept up to date.
2. Appeal is made to staff by staff president.
3. Letter is written by the secretary of the board of trustees to each member of the staff explaining the importance of keeping records complete and up to date.

"Our efforts have some good effect," says the administrator who outlines this procedure, "but they are not entirely satisfactory."

Some Admit Fee Splitting

Only two hospitals in the participating group are aware that any staff members are guilty of fee splitting. One of these states frankly that the practice is carried on—under cover. The other adds this comment:

"In the past we have had some difficulty with fee splitting. However, we discuss this question openly in staff meetings and, as a result, a physician who has been guilty hesitates to attempt the same trick again, and those who might be tempted are restrained.

"There are a few black sheep among the profession here, but they are well known to all hospitals and are not difficult to handle."

Several of the hospitals reported emphatically that no evidence of fee splitting had ever appeared. One administrator presented this reply:

"The matter of fee splitting had caused me concern for some time. However, at the time I received this question, I showed it to the physicians involved and asked them how I should answer it. Their explanation clarified the question in my mind. The answer here is: No fee splitting."

Several hospitals report that the absence of younger staff members who have been away serving with the army and navy has had a demoralizing effect on the maintenance of staff records, attendance at clinical conferences and other phases of medical staff performance. The return of these younger men, it is felt, will have a stimulating effect generally and bring about quick improvement in all these matters. One or two hospitals, in fact, are making the return of veteran staff members the occasion for thoroughgoing staff reorganization with a view to achieving better all-around results in all these important phases of the hospital's service.

VOLUNTEER ACTIVITIES

First Ten Years Were Lively

The first ten years in the life of the Woman's Auxiliary of Evanston Hospital, Evanston, Ill., have passed and what a stirring life it has been! Like a cat, this group has really nine lives for the auxiliary sponsors that many separate enterprises. These are the shop, baby alumni fund, memorial fund, nursing committee resale for nurse scholarship fund, occupational therapy, outpatient department, patients' library, premium coupons and sewing group.

In these first ten years the auxiliary has contributed $30,568.18 to the hospital and $3225 in scholarships to Evanston Hospital nurses for postgraduate study.

Besides these contributions much equipment has been purchased for the nursery and other departments through proceeds from the auxiliary's annual benefit party and its numerous other activities.

More Than Service

"Besides the actual service [42,123 hours last year] which volunteers gave to patients, there is so much that is intangible," declared Elizabeth Odell, director of the school of nursing at Evanston Hospital, Evanston, Ill., in her report to the annual meeting of the Hospital Association.

Among the intangibles Miss Odell lists are: "the lift to the morale of head nurses and students who day after day see more work ahead than they can possibly do well; the cheerful atmosphere that volunteers bring to patients from the outside; the unfailing courtesy and ethical performance of the whole group."

Other department heads also spoke their appreciation, as volunteer service other than nursing assistance brought the total for 1945 up to 50,000 hours in this one institution.

Children Are Their Specialty

One of the active clubs in Chicago is the Service Club, which recently opened recreational and occupational therapy rooms at Cook County Children's Hospital, a project on which these women have worked for two years.

Until the rooms opened this summer, children at the county hospital had to amuse themselves in bed during their convalescence. The occupational therapy room has special bicycles, steps, looms and wheel chair tables.

In the recreation room are 24 little powder blue chairs and an equal number of terra cotta chairs and 10 tables. Members of the Service Club spent 150 hours painting these chairs and tables. There are toys and therapeutic tools galore.

Benefit for Babies

Five years' experience with garden parties has paid off for the Baby Home Auxiliary of the Lutheran Home for Orphans and Aged at Germantown, Pa. In 1940 the women cleared slightly more than $2000 on the party and last year the net proceeds were $4300. This September, the weatherman cooperating, the group expects to exceed the 1945 maximum. The auxiliary recently celebrated its 31st birthday.

$400 Furnishes a Room

Some of the private rooms at Yonkers General Hospital, Yonkers, N. Y., have begun to look a little down at heel so a campaign is now under way to refurnish and redecorate them completely. To start things off, the board of directors, the junior committee and the Ladies' Aid each have contributed $400. The women's groups are interesting clubs and churches in redoing rooms at the $400 rate. In recognition of such generosity a bronze plate is placed on the door of each room crediting the donor group.

ABOUT PEOPLE

Administrators

Carl I. Flath will report to Queen's Hospital, Honolulu, T. H., in September or early October to assume the directorship following the retirement of **G. W. Olson.** Queen's is anticipating an ambitious expansion program, both physical and educational.

Mr. Flath, former superintendent of Wellesley Hospital, Toronto, Ont., former assistant director of Michigan Hospital Service and lately administrator of Charlotte Memorial Hospital, Charlotte, N. C., has been a member of several A.H.A. committees and councils, including the Council on Public Education, the membership committee, the personnel committee and the committee on inclusive rates which he served as chairman. He is an editorial consultant of The MODERN HOSPITAL and a frequent contributor to hospital literature and to professional organizations.

Dr. James H. Wall has been appointed head of the Westchester Division of the New York Hospital, White Plains, N. Y. Dr. Wall succeeds **Dr. Clarence O. Cheney** who is retiring after ten years of service.

John W. Rankin has resigned as superintendent of Tuomey Hospital, Sumter, S. C., to become superintendent of James Walker Memorial Hospital, Wilmington, N. C. Mr. Rankin is president of the South Carolina Hospital Association, secretary of the board of directors of the South Carolina Blue Cross Plan and a member of the A.H.A.

William J. Donnelly, administrator, Greenwich Hospital, Greenwich, Conn., has assumed the duties of secretary of the Connecticut Hospital Association, succeeding **Howard S. Pfirman,** Middlesex Hospital, Middletown, who has been obliged to resign for reasons of health.

Dr. Ralph Schwartz has been appointed administrative assistant, Beth Israel Hospital, New York City. Dr. Schwartz was recently discharged from the army medical corps after serving forty-five months in France.

T. F. Henley, is the new manager and superintendent of Bishop Clarkson Memorial Hospital, Omaha, Neb. Mr. Henley was captain in the medical administrative corps during the war and was head of several departments in the army hospital at Fort Benning. After his separation from the army, Mr. Henley returned to Ellis Hospital, Schenectady, N. Y., to survey the dietary department. He was auditor and business manager at Ellis Hospital before entering the service.

A. L. Howarth has resigned as superintendent of Central Washington Deaconess Hospital, Wenatchee; his successor is **Chester Finkbeiner.** Mr. Howarth will become superintendent of the hospital's expansion program, serving as consultant to the trustees and architect, as purchasing agent of new equipment and as a member of the campaign committee. He has been president of the state hospital association twice in the last five years and will continue as a trustee of that association and also his Western and A.H.A. association connections.

Clyde W. Fox is the new administrator of Tucson Medical Center, Tucson, Ariz., succeeding **Charles S. Aston Jr.** who resigned. Mr. Fox left army and U.N.R.R.A. service to accept the post at the medical center, which is on the 160 acre grounds of former Desert Sanatorium. A new surgical unit, x-ray and laboratory facilities and rooms for an additional 75 patients are contained in a new unit almost completed which will bring the hospital's capacity up to 175 beds.

Dr. Henry N. Pratt has been appointed administrator of Memorial Hospital for Cancer and Allied Diseases, New York City. Dr. Pratt, following his army duties where he gained colonel's rank, became instructor in pediatrics at Harvard Medical School and associate physician at Children's Hospital, Boston.

During his army service, Dr. Pratt was commanding officer of an imposing array of hospitals overseas: Waringfield Convalescent Hospital in North Ireland; 3d General Dispensary at Cheltenham, England; 16th Station Hospital, London; 48th General Hospital, Paris; 16th General Hospital, Liege, Belgium, and Chalons-sur-Marne, France. Several of these units were recommended for War Department citations. During the Battle of the Bulge, his hospital in Paris admitted 1142 patients and evacuated 502 in eighteen hours.

Dr. Andrew C. Ivy has been appointed to the newly created position of vice president in charge of the Chicago Professional Colleges of the University of Illinois and distinguished professor of physiology in the graduate school. Dr. Ivy, who was professor and head of the division of physiology and pharmacology, Northwestern University Medical School, succeeds **Dr. Raymond B. Allen,** former executive dean of Chicago colleges, and will be the chief administrator of the University of Illinois' colleges of medicine, dentistry and pharmacy and of its hospitals and institutes.

Mrs. E. W. Johnson, formerly of Clark General Hospital, Vancouver, Wash., is the new administrator of Sycamore Municipal Hospital, Sycamore, Ill., a 32 bed institution.

Frederick A. Sharp, formerly administrator of Margaret Pillsbury Hospital, Concord, N. H., is serving as superintendent pro tem of Monadnock Community Hospital, Peterborough, N. H.

Ruth E. Johnson, R.N., who received her degree in hospital administration from Northwestern University in June, has been appointed administrator of Christ Hospital, Topeka, Kan.

Henry N. Wallace became head of Children's Hospital and Children's Hospital Convalescent Home, Los Angeles, Calif., on August 1. He recently resigned as superintendent of Washoe County Hospital, Reno, Nev., a position he had held since December 1942.

Morton Bennett for two years assistant superintendent of Worcester City Hospital, Worcester, Mass., has been appointed superintendent of Salem County Memorial Hospital, Salem, N. J.

Clara E. Boeck has succeeded Mary J. Johnson as superintendent of Union Hospital, New Ulm, Minn.

Elvy Anderson, former anesthetist at the University of Michigan Hospital, has been appointed superintendent, and **Paul Anderson,** a veteran and former hospital attendant, has been named business manager of Warren Hospital, Warren, Minn.

(*Continued on Page* 148.)

TRUSTEE FORUM

CONDUCTED BY RAYMOND P. SLOAN

Planning for the Hospital-to-Be

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Washington, D. C.

THE planning of a new hospital today is a far more complex, and difficult task than it has been in the past. The reason, briefly, is that the concept of a hospital's function, its obligation to and its place in the community is continually broadening.

It is no longer true that the voluntary general hospital is merely a place for the care of the sick or a doctor's workshop, as we so frequently hear it expressed. It is that and much more. Its duty to the citizen who may never occupy a hospital bed is hardly less important than its duty to those who do. This duty is discharged in part through the provision of modern clinical facilities wherein all qualified doctors of medicine in the community may advance their knowledge of medical science.

Provide Care of Equal Quality

A hospital has the further duty, whenever possible, of providing well trained nurses and interns to serve the community. It has a duty to the local government to be discharged through close and effective cooperation with public health and welfare officials. It has the moral duty in common with all citizens to provide care of equal quality to poor and rich alike. Clearly, the discharge of such responsibilities can be accomplished only by an organization firmly founded on cold facts without emotional or provincial bias.

The new hospital-to-be is both a highly technical and expensive undertaking, with both these qualities on the increase. Initial thoroughness in establishing basic requirements will return endless dividends in improved patient care and community health. Failure to evaluate these needs carefully may well result in needless expense, disappointment and a second-rate institution.

Once the decision to build has been made, the next question is the number and kind of beds the community requires and the types and extent of related services to be provided.

Need Should Be Measured

Despite the many factors entering into the determination of institutional need, population to be served remains one of the most tangible and stable of these factors. Even so, need measured in terms of bed-population ratios alone may have many pitfalls.

The ratio most frequently heard, perhaps, and one which we have used is 4.5 general hospital beds per thousand population. This figure is not wholly arbitrary. It corresponds closely with several experience figures based upon broad segments of the population under conditions of reasonably free access to hospital care. Since this ratio is based upon experience of broad groups, it follows that a comprehensive type of service is implied. In other words, this ratio might well be too high for the small community whose medical personnel consists of general practitioners only.

On the other hand, 4.5 beds per thousand will certainly be too low if based upon an urban population in which a medical center attracts patients from wide areas. This implies that the number of general hospital beds in any community must be adjusted not only to the population to be served but also in accordance with the comprehensiveness of service which the community may reasonably expect to afford.

Some Cases Must Be Referred

It should be made clear that this does not mean that rural communities require materially less hospital care per capita than do urban communities. It does mean that of necessity a certain percentage of cases in rural areas requiring the services of specialists must be referred to hospitals farther away.

Once the total number of beds needed in the new hospital is determined, the next question is the number of beds to be provided for each type of service. Formerly, such decisions were concerned primarily with the number of beds in private rooms, the number in semiprivate rooms, the number in wards, the number to be assigned for obstetrics. Recent well defined trends in hospital service are introducing additional elements to be considered in the planning of all general hospitals. There is now a trend toward making the general hospital more nearly what the term implies: an institution capable of caring for all common types of illness.

Communicable disease is certainly one of the most neglected of all illnesses requiring hospital care. In the smaller cities the pesthouse type of institution is an all too familiar sight. Frequently, we see a nondescript building completely isolated from any other institution and standing

Presented at the convention of the Ohio Hospital Association, Columbus.

empty much of the time. Often, it has no administrative relationship with any other hospital. The quality of care given in such institutions is self evident.

In many towns and smaller cities we find no provision at all for the occasional cases of communicable illness. General hospitals, particularly the voluntary hospitals, have in the main steadfastly refused to make provision for the care of such diseases. The reason for this has not been so much the danger of cross infection, real or fancied, as a matter of inconvenience and perhaps extra expense to the hospital. Future hospitals with a view to serving the public as fully as possible should plan to accommodate these cases. The need is very great.

More Attention to Other Illness

Communicable illness is mentioned merely as a case in point. In the larger general hospitals, in particular, still other special types of illness appear certain to receive more attention in the future, *i.e.* acute tuberculosis, acute mental disturbances and chronic illness. The degree to which these services are incorporated into the physical facilities in the organization of the new hospital will be a matter for local determination in each instance. The desirability of having these patients under the immediate care of the general hospital staff is beyond all question.

It has already been pointed out that the community hospital, even though under voluntary auspices, has an obligation to the public health officials in its community. This obligation is especially important in communities in which the entire hospital facilities are represented in one institution. There is a growing trend toward incorporation of special clinical and administrative facilities for the use of public health authorities.

Another trend—and one that is applicable to both large and small institutions—is the provision of office space and laboratory facilities for private physicians and dentists. Advantages from this arrangement accrue to the hospital, the doctors and the community alike. The hospital gains in several ways. It has a source of revenue from the rental of office space. The proximity of the staff physicians is a convenience to the hospital and its patients.

The doctor benefits, especially in these times of critical housing shortages, in that he can find convenient and well appointed office space. He also benefits from the ready accessibility of laboratory and other diagnostic aids. The public gains from the fact that any added inducement to practice in the community may help to relieve the shortage of physicians and dentists, which promises to remain acute for several years to come.

Still another service feature must be given serious thought by the hospital planners; that is the need for an outpatient department. Relatively few of the smaller hospitals provide an outpatient service as such. Yet, no other service the hospital may offer to the public has such potentialities for good in the community. No other service can contribute so much to the public health and health education of the people. No other service offers such valuable opportunities for giving nurses and interns an insight into community health problems.

One of the most important of all the special features to be considered is the school of nursing. In the larger general hospitals, a nursing school will probably be planned as a matter of course. In hospitals of fewer than 100 beds and, in particular, those of fewer than 50 beds, the matter must be considered with increasing care. Higher standards of nursing education are now a fact and will continue in the future. This will tend to increase the necessity for affiliation for the smaller schools.

Reverse Affiliation Procedure

If the hospital planned is to be in the smaller category, it may be preferable to plan to receive affiliates from larger training schools and colleges that conduct schools of nursing; this is a reversal of the affiliation plan so as to receive students after the first year of basic education instead of sending out students in their second or third year.

The proper evaluation of all the factors affecting the hospital organization can be made only by a qualified hospital consultant, one with practical experience who is able to visualize the community needs, appraise the ability of the community to meet these needs and then plan the subsequent steps necessary. This includes, among other things, means of financing, type of staff organization, physical structure and equipment. In all these determinations the consultant must work in close cooperation with the hospital superintendent, the architect, the doctors and the hospital committee.

It has been said that too little attention has been given to functional planning of hospitals. Only too often this results in unattractive exteriors and inefficient interiors. Failure to plan the structure properly will almost certainly result in excessive costs in both construction and operation. It is important, therefore, that the architect selected have hospital planning experience and an insight into hospital operations. He will plan the building around the functions to be performed. This is the only approach to a satisfactory result.

Influences Other Areas

It should be emphasized at this point that the influence of a community hospital is rarely confined to one community. This is particularly true of the hospital that offers a variety of specialized services. Now that the country is facing the accumulated need of several years, the necessity for overall or statewide planning is even more apparent.

Last, but by no means least, the decision must be made as to the type of authority under which the hospital is to operate. There are a number of good methods, including church and fraternal organizations. In most communities, however, the choice will lie between county or municipal auspices and a voluntary nonprofit association. When the institution is to be financed through a county or municipal bond issue, control will doubtless be vested in a public authority. When the funds are to be raised through private subscription, the hospital will usually be organized under voluntary nonprofit auspices.

The type of organization the new hospital is to take should in no way affect the type and quality of service provided. It must ever be remembered that the community hospital belongs to and should be responsive to the needs of the community. This responsibility should be exercised through a board of trustees that represents impartially the best interests of the public. The success of any hospital rests largely with its board of trustees.

Never Underestimate the value of internship

FRODE JENSEN, M.D.
Council on Medical Education and Hospitals
American Medical Association, Chicago

INTERNSHIP has played an important rôle in the development of high standards of medical education in this country. For well over thirty years the value of training young medical graduates for another year or more in hospitals before they enter the practice of medicine or postgraduate training has remained unchallenged by educators. Since this program began, the Council on Medical Education and Hospitals of the American Medical Association has stood by it and guided it along the path of growing success.

Entirely on a voluntary basis, a large number of civilian hospitals has adopted the principle involving the council approved internships. These 743 hospitals approved for internship training stand ready to accommodate approximately 8427 interns. Note that I say *stand ready* to accommodate, and not that they *are* accommodating that number.

Reveals Deficit of Interns

The statistical data published in the recent hospital number of the *Journal of the American Medical Association* reveals some interesting facts. The report indicates that during 1945 there was actually a deficit of 2840 interns; a better way of stating this fact would be to say that our medical colleges were not in the position to graduate enough doctors to fill the total number of 8427 internships offered by the hospitals in this country.

In the educational number of the *Journal* published late in 1945, one may observe that the estimated number of medical students to be graduated in 1946 totals about 5337. Simple arithmetic indicates that 1946 will see a deficit of 3090 interns, a sizable number when one realizes that it implies 27 per cent of the internships offered by civilian hospitals.

Today it is as true as ever before that the fourth year medical student selects the hospital in which he wants to intern on the basis of its reputation as an educational institution. It cannot be denied, however, that such factors as geographic location and personal aspects play a rôle when the senior student comes to choose his hospital.

I am quite convinced that the stipend offered hardly enters the good student's mind and that he does not seek out the hospital that pays the most. There are civilian hospitals that pay as high as $165 per month, plus maintenance. I am aware that, generally, the least reputable hospitals offer the most pay and I shudder to see the old established hospitals of considerable renown competing for interns on a salary basis rather than on the accepted and approved basis of educational merit.

I often encounter hospital superintendents who glibly pass off their misgivings in this direction by saying that they need interns to work up patients who otherwise would not be properly looked after. Also, I meet doctors—staff members of various institutions—who say that we cannot expect good chart work when there are not enough interns and that to obtain interns they have to compete with other hospitals on a salary basis. The hospital that favors such a policy is, by the very nature of this type of thinking, defeating its own purpose and cannot hope to be looked upon with favor by the medical student.

A.M.A. Lists Essentials

The A.M.A. Council on Medical Education and Hospitals has set down some simple rules and regulations pertaining to a good internship that are regarded as essentials:

1. A hospital that expects and wishes to remain approved for intern training must meet all requirements in maintaining clinical records; the record room should show capable directorship and modern nomenclature and proper indexing must be followed.

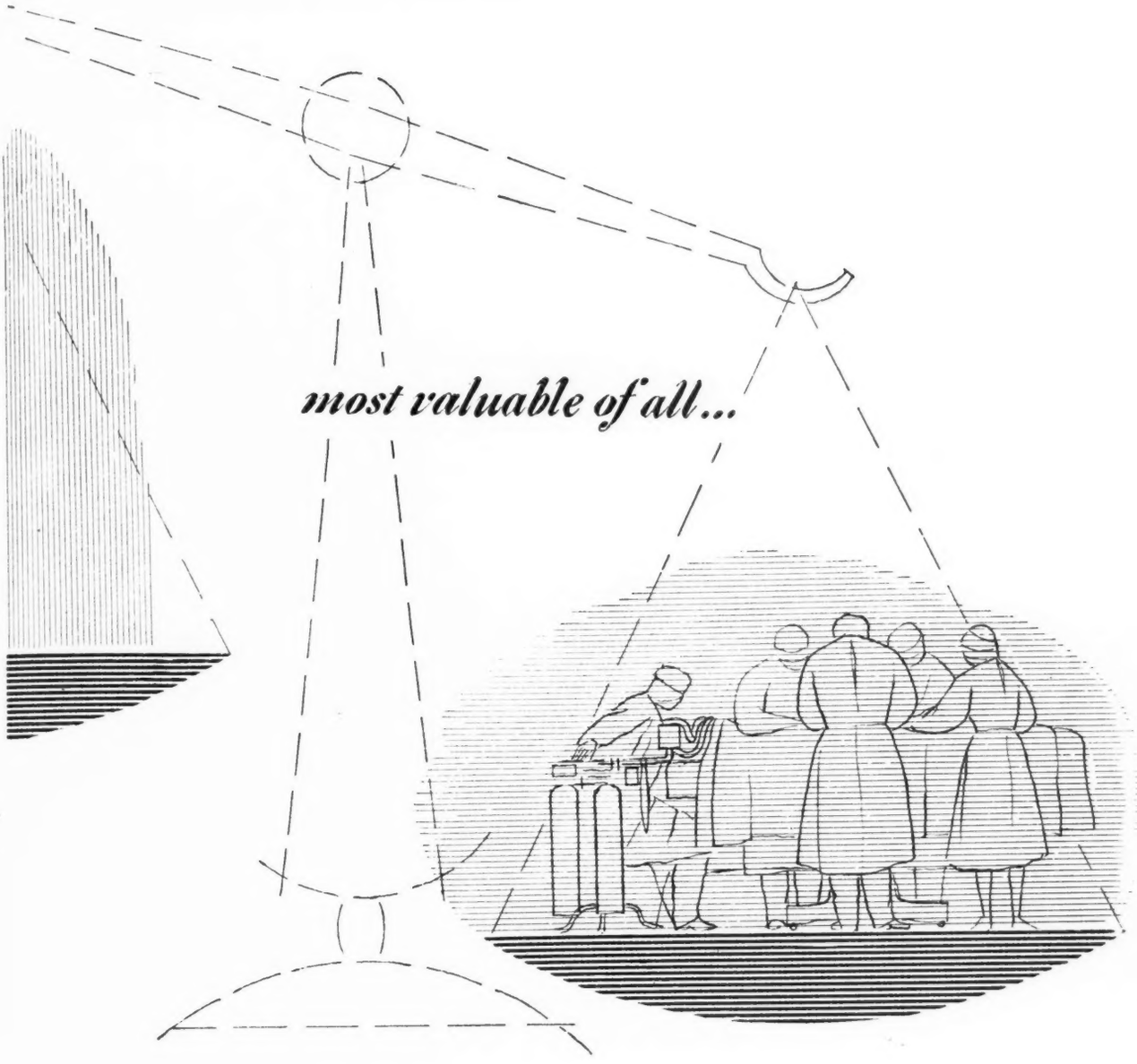
2. The hospital must maintain adequate facilities for a library of up to date text and reference books and a selected number of medical journals.

3. A necropsy performance of not less than 15 per cent of hospital deaths is required.

It is of interest in this connection that many hospitals are urgently asking for approval although they consistently fail to reach and maintain this required standard of performance.

Recently I reviewed the data pertaining to the highest necropsy rates in the hospitals approved for internship and discovered that, contrary to a general opinion among hospital staff members, of 67 hospitals that attained the highly commendable annual necropsy rate of 70 per cent or over during the last ten years, 51 were nonprofit institutions and not state, city or county sponsored.

Presented at the Tri-State Hospital Assembly, May 1946.



"... even recognizing other newer experimental anesthetics, we still might say that *ether is the most valuable of all* and that the discovery of its anesthetic effects was one of the most important milestones of medical progress."*

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SQUIBB Ether

*Walton, R. P.: History of Anesthetic Drugs. J. South Carolina Med. Assoc. 40:60 (March) 1944.

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

Generally speaking, these criteria tell us to what extent a hospital is qualified to train fifth year medical students. That a hospital must have a sufficient number and variety of admissions and that the staff must be qualified and working in an accredited institution go without further comment. Thus it seems apparent that the intern problem in hospitals is often a local one.

Naturally, hospitals affiliated with medical schools enjoy a favorable position while small hospitals in rural areas do not. Many of these hospitals are faced with the definite problem of obtaining interns and at the same time of maintaining an alert staff interested in medical education. A goodly number is on the brink of tossing aside the idea of training interns altogether and is becoming more interested in offering hospital training at the resident level.

Seek Approval for Residencies

Several of these institutions have made applications for approval in this direction and others are requesting inspections for residencies in special fields over and above their already approved residencies. Likewise, the navy is extending its teaching facilities for residents and interns, and the army is planning a similar program for the civilian fifth year and postgraduate medical students.

Much of this activity in the postgraduate field is a result of intense interest shown by the veterans in postgraduate training. At the moment at least there appears to be a larger pool of veterans than the hospitals are able to take care of. How long this state of affairs will exist it is difficult to tell, but I doubt if it will last three years and, certainly, not more than five years.

One might ask, what will those hospitals that are apparently putting all their eggs into one basket do when the pool of veterans is drained dry? Can they hope to stimulate enough interest in postgraduate training to maintain their quotas of residents? Should they be successful in this effort, there is danger of resultant crowding of the specialty fields.

Not long ago I surveyed the educational training program of a well known hospital. Many of the accomplishments regarding intern training

obtained through many years of effort were about to be tossed to the wind by the staff of this hospital. It was contemplating a drastic reduction of its intern staff and an equally drastic increase in the number of residents. Instead of the usual 12 interns, only four would be required, and instead of the usual four residents, the hospital planned to have 12. All attention was focused on residents; the interns were hardly considered in the hospital training program.

How can this hospital hope to build a successful postgraduate educational program on top of a neglected and poorly conducted intern training program? When there is no longer an abundance of men looking for postgraduate training, what will this hospital do? Will it revert to its former quota of 12 interns? I cannot answer that question, but I am sure that during the years the intern training program is reduced to a bare minimum this hospital will suffer a setback as far as its reputation among prospective interns is concerned.

What then can be suggested to solve this problem? At the outset we all agree that the intern year in the hospital is a vital part of medical education. We now find ourselves under the necessity of making some adjustment. The pendulum has swung toward emphasis on specialization. Whether this is a healthy state of affairs remains to be seen. If, in time, all our doctors are to become specialists, who then is to become the specialists' specialist? And what will become of our honorable general practitioner? Would it not be advisable to put on the brakes before we get going too fast and return once more to a program where emphasis is again placed on the internship which, after all, has proved its value beyond a doubt.

Instead of giving a man a swift kaleidoscopic view of the various essentials of a rotating internship on a one year basis, why not extend to him the privileges of a two year internship? This would allow him more time on the various services. I would even go so far as to recommend that the two year intership should become a prerequisite for the practice of medicine, with the proviso that those who are aspiring toward qualification in one of the specialties be permitted to take one year of internship, as is now generally the case.

I believe that a majority of those who are interested in medical education would agree that this would be a worth while change-over and the problem of obtaining interns in hospitals would in a large measure solve itself.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Hysterectomy Justified?

Norman F. Miller, writing under the title "Hysterectomy—Therapeutic Necessity or Surgical Racket?" in the June number of the *American Journal of Obstetrics and Gynecology,* comes to the conclusion, after a study of a considerable series, that the clinical diagnosis was confirmed in only half the cases. In 17.4 per cent the clinical diagnosis was not confirmed, but the operation was nevertheless considered justifiable. In one third of the patients either there was no disease or else there was disease that contraindicated hysterectomy.

The author naturally comes to the conclusion that while the question asked in the title of his article may not be answerable on the basis of the limited material of his study, we may be sure that "when the curtain rises we shall witness a tragedy, painful and far-reaching in its implications." It seems to us that hospital administration has a deep interest in such statements appearing by reputable authors in reputable medical journals.—E. M. B.

Improved Obstetrical Service meets general approval

DONALD G. TOLLEFSON, M.D.
Moore-White Clinic
Los Angeles

THE trend in obstetrical care must be toward constant improvement in service to patients. Even though the length of stay in the hospital continues to be shorter because of the shortage of beds, that stay must be better supervised and the patients must receive more attention. To do less will cause our public relations to suffer and it is in need of much improvement right now.

Individual attention, of necessity, was greatly reduced during the war. However, many lessons were learned which we should not disregard now that the war is over. Bathing of patients is no longer a necessary task of the nurses after the third day in the normal postpartum woman. Care of the perineum is no longer the complicated procedure that was adhered to for so long and competent attendants can be taught the new technic.

Mothers should be taught proper methods of nursing the baby. The nurse can build up morale by educating the mother in the value of breast feeding.

Another important individual problem is proper bed exercise. It is not sufficient simply to hand the patient a typewritten slip and say "Take the exercises." These exercises are important in promoting the proper involution of the pelvic organs and body musculature.

We should again give the patients training in bathing and diapering infants and in other important routines necessary to the baby's welfare.

Adequate nursing care is still the biggest problem which hospitals must meet. During labor, when analgesia is used, the patient requires constant nursing attention. If this care is not furnished by the physician, it remains a hospital responsibility. An extra charge for this service should not be objectionable.

At California Hospital, Los Angeles, with an average census of 52 babies, 34 graduates, nine students and 11 attendants are required for the delivery room, nursery and floor service. Twenty per cent of the patients are premature or sick infants who require 80 per cent of the nursing care. It would seem advisable that we recognize the need for premature infant care as a special service to the patient, and an extra charge for such service would be entirely justifiable.

The nursery requires approximately the same number of nurses and attendants as do the floor patients. We have done much to decrease the general work of the nursery by trying to limit formulas to four stock types. We have also reduced the number of weighings and temperature readings.

The delivery room technic and setup were streamlined for the war. We reduced the number of sizes and types of suture material from 20 to four and reduced the number of instruments from 60 to 20. This means less washing and sterilizing. Instead of seven prep technics, we have one. This should not be changed.

Through education, visitors to patients were sharply curtailed on the maternity floors. This was a necessity and a great improvement, but it would seem now that the restrictions should be lifted somewhat.

The obstetrical department is the greatest producer of good will for the hospital. It needs to be carefully guided and improved. The cooperation of the staff and the public has been excellent. Let us not lose what we have gained by restrictions but, also, let us not continue what is not necessary. We must improve our position by the best possible service to our patients for that good will which is so essential in carrying on the work of the voluntary hospital.

Presented at the hospital conference of the American College of Surgeons, April 1946.

SAFEGUARDING
The Use of New Drugs

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Food and Drug Administration
Washington, D. C.

THE great advances which have been made in the field of pharmacology have served to emphasize that as more and more facts have been uncovered concerning the actions of drugs, many undesirable and even dangerous side actions have also come to light. Many of the older drugs have been employed in medicine for so many years that their action and limitations have become fairly well established. Nevertheless, even these can be dangerous when abused.

Acetanilid and its preparations in headache mixtures may be cited as an example. Synthetic organic chemistry has created countless new drugs which in the past were introduced into medicine with only a perfunctory examination regarding their efficacy and safety. The evils of this system can be readily appreciated when it is recalled that more than 100 people died as the result of taking an elixir of sulfanilamide prepared with diethylene glycol.

In order to afford greater protection to the public where new drugs are concerned, it became imperative to place certain legal restrictions on the introduction of new and untried agents into commerce. On June 25, 1938, the Federal Food, Drug and Cosmetic Act became effective, which corrected and improved many of the shortcomings of the old Food and Drug Act of 1906.

The new act stipulates that it is illegal to introduce into interstate commerce a new drug unless application has been filed with the Federal Security Agency and permitted to become effective. The application must contain a full and complete statement of such matters as the components, composition, manufacture, packing and labeling and, most important of all, a full report regarding the investigative work that has been undertaken to evaluate the safety of the new drug under conditions of use.

The therapeutic efficacy of the new drug has no bearing on whether or not the application becomes effective. The matter rests principally on the information supplied, which permits of arriving at a decision regarding the safety of the new drug under the conditions that have been recommended.

In the practice of medicine the physician can prescribe any drug he chooses and he can appraise the therapeutic usefulness, or lack of it, of a new agent; but for many reasons he is not in a position to evaluate the hazards of such agents. The public must be protected against dangerous medicaments, and this is the function of the 1938 act.

Appraising the Hazards. It is relatively easy to reach a decision regarding the safety of a new drug when little or no toxicity is shown by the substance. One of the best examples to illustrate this is penicillin. It is also not difficult to screen out the substances which possess predominant toxic manifestations under the conditions of use, *i.e.* diethylene glycol. The greatest problems arise between these two extremes where a drug possesses certain desirable attributes but also manifests some undesirable actions to a greater or lesser degree.

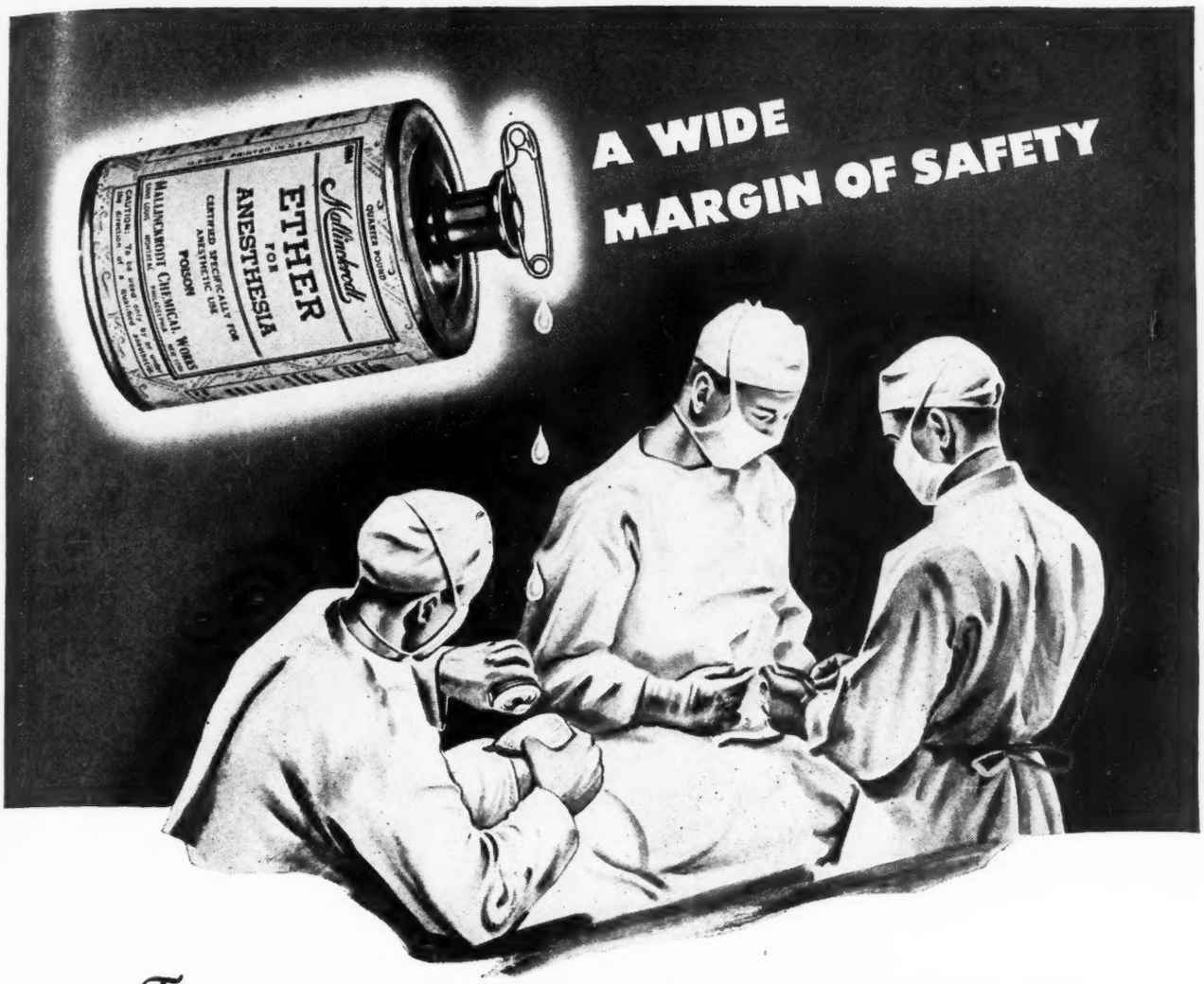
Under these circumstances it is necessary to consider carefully the therapeutic efficacy along with the potentialities to do harm. A good example of how overemphasis of one or the other of these categories can actually delay the introduction of a valuable drug is found in the history of oxophenarsine, better known as mapharsen.

Research Work Stopped

This antisyphilitic was first investigated by Ehrlich, who thought that the drug was too toxic for clinical use. As a result, no further work was done on the compound and other analogs were developed and studied. Arsphenamine was eventually discovered and considered the best spirocheticidal agent of the series. The toxicity data indicate that oxophenarsine is 10 times more toxic than arsphenamine.

It was not until a quarter of a century later that oxophenarsine was reappraised not only on the basis of its toxicity but also on its therapeutic efficiency. It was found to possess a high antispirochetal action. When the hazards under conditions of use were considered, it was shown that with oxophenarsine about one death occurs in something more than a million injections.

In contrast with this, arsphenamine may produce one fatality in approximately every 42,000 injections. Nonfatal reactions occur only about one seventh as frequently with oxophenarsine as with arsphenamine. It is therefore obvious that although the therapeutic efficiency of a new drug is not the deciding issue which determines whether or not it



Two of America's leading anesthesiologists recently stated: "Drop ether still remains one of our safest anesthetics."[1]

Safety of the anesthetic agent is of particular importance for the patient in shock. In such cases, "the safest agent, for experienced and inexperienced anesthetists alike, is ether. Its value has been proved in nearly 100 years of continuous use during which many million operations must have been performed. It is the agent with which we have the most experience, which has the widest margin of safety, which has been most carefully investigated both in the laboratory and under clinical conditions."[2]

For extensive procedures in which regional anesthesia is not applicable, ether and oxygen administered through a gas machine is the anesthetic of choice. The method used should be intratracheal, as it will enable the anesthetist to keep the operative field clear for the surgeon, and eliminates all difficulty in maintaining a free airway.[3]

1. Editorial: Anesthetics Old and New, Anesthesia and Analgesia, 23:44, Jan.-Feb. '44.
2. R. Blair Gould: Anaesthesia for the Patient in Shock, Anesthesiology 5:129, March, '44.
3. Major C. F. McCuskey: Anesthesia At The Front, The Military Surgeon, April, '44.

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is introduced into commerce, clinical experience with the agent does enter into the final appraisal regarding safety.

Principles Involved. When it is kept in mind that the primary objective that motivates the development of new drugs is to incorporate greater therapeutic usefulness with a minimum of possible dangers, the necessity for logical methods for appraising such usefulness and potential harmfulness becomes obvious. No set rules can be put down as to the exact procedures to follow. These are left pretty much in the hands of the investigators. However, it may be of interest to sketch briefly the general principles employed in making an appraisal of a new drug.

A new drug usually passes through three phases of investigational work in order to supply data which may serve to support the claims made for it. The first phase consists of preliminary skirmishes in an attempt to determine the field of usefulness. Chemotherapeutic agents are tested against certain experimental infections. Drugs with more diverse effects may be examined for certain pharmacodynamic actions.

If the preliminary data indicate that the drug shows promise, then more extensive investigations are in order and the observations pass into the second, or laboratory, phase. The general types of study applicable here include the biochemistry of the substance, which usually covers absorption, distribution, fate and excretion.

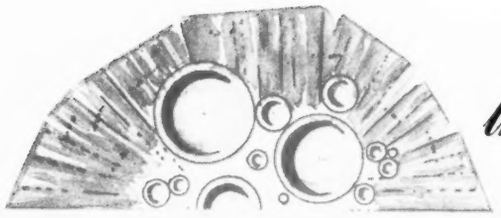
Pharmacodynamic studies include the local and systemic effects. Tests of irritation to the skin, alimentary tract and mucous membranes, and blood pigment changes may be listed as studies of local action. Systemically, the action on most or all of the functions of systems and organs may be investigated. This may be extended to include the effects on experimentally induced pathological conditions.

Toxicology Is Investigated

Ordinarily, investigations like the foregoing serve to disclose any undesirable actions of a new drug. A more complete appraisal is usually made by investigating its toxicology. This embraces observations on the acute effects of single doses, large and small, on animals. Subacute effects are determined by administering large doses daily for an extended period of time and chronic studies deal with actions of several dosage levels on a series of animals, administered sometimes throughout the life span of the animal.

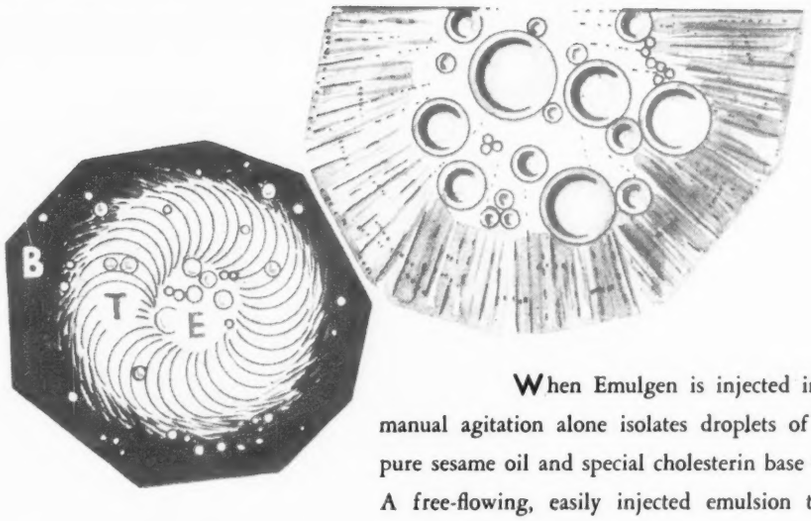
When sufficient information from the laboratory standpoint has been accumulated to permit of a satisfactory appraisal regarding possible clinical applications, the new drug enters the third phase of the work. This is concerned with the therapeutic usefulness, limitations, tolerance, effective dosage range, contraindications and precautions for use of the new agent as determined in the clinic. Finally, the various phases of the work are compiled and a critical evaluation of the data is made.

If the primary objective has been attained as to constancy of action and margin of safety and the hazards are not severe enough to militate against further use of the drug, then an order may be issued by the administrator of the Federal Security Agency permitting the new drug application to become effective.



the injection vehicle for

SLOWER PENICILLIN ABSORPTION



Schematically, aqueous penicillin bearing droplets **E** injected into the muscle are released slowly through the tissues **T** into the blood **B** as the enveloping sesame oil emulsion (Emulgen) is absorbed.

When Emulgen is injected into a vial of penicillin solution manual agitation alone isolates droplets of penicillin-bearing water in the pure sesame oil and special cholesterin base of this new emulsifying vehicle. A free-flowing, easily injected emulsion thus is formed quickly and at room temperature.

After the creamy water-in-oil emulsion formed by Emulgen has been deposited in intramuscular tissue the fine droplets of penicillin solution pass into circulation only as their lipid sheaths are absorbed. Utilization of the injected dose of penicillin is greatly prolonged so that convenient 8 to 12 hour intervals may separate injections.

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FOOD SERVICE

In the Army They Really Had Problems

ROBERT M. SCHNITZER
Assistant Administrator, Orange Memorial Hospital, Orange, N. J.

AS WE look back on world history and review the wars which have plagued man from one generation to the next, we cannot help but notice how complicated and specialized warfare has become. Where once combat was little more than hand to hand fighting with bodily strength and manual skill the paramount individual asset, today's battles are fought by individuals based up to a thousand miles behind the front lines, whose contributions come from all sorts of training and civilian occupational specialties.

Within only a short while after being commissioned in the army I began to appreciate the need and use for these specialties when it became evident that our mission in this war was to achieve a victory by giving the man doing the fighting the advantage and protection of the best in equipment and weapons and by having readily available every facility for saving life and limb for those so unfortunate as to be injured.

Uncle Sam Went Too Far?

However, just as there is the danger of teaching a football team too many plays to be remembered, there is also the likelihood of overspecialization spreading the work and responsibility so thinly that an organization becomes cumbersome and ineffective. I thought Uncle Sam had at last gone too far when, following the Sicilian campaign, he ordered a dietitian to report to our evacuation hospital.

On hearing this news there flashed through my mind the monotonous and limited rations during the African campaign. There had been corned beef hash, vegetable stew, meat and beans, cold corned beef, powdered eggs, hard crackers in place of bread and, occasionally, a few canned vegetables, in addition to that now famous luncheon meat delicacy, spam. What else could one do with this meager fare which had been precooked, dehydrated and baked, except add water, heat up, apportion and serve?

During the coming months, however, as our unit moved on into Italy, Southern France, Alsace-Lorraine and deep into Southern Germany, I came to appreciate the contribution being made by our detitian through her interest in the comfort and welfare of the wounded and her assistance in diet therapy to the medical staff. It was not easy by any means, and I imagine many times she felt frustrated by the limitation of rations, equipment and personnel.

To give some idea of the conditions under which our dietitian worked I should tell a little about an evacuation hospital. Depending on the tactical situation and rapidity with which the front lines moved forward, an evacuation hospital was located in the combat zone from 15 to 50 miles from the actual fighting. The wounded were given first aid on the battlefield by medical battalion aid men of the division to which they were assigned and assisted or carried by litter to a collecting point.

Here, they were placed in ambulances and transported a few miles to a clearing station where their dressings and splints were adjusted and more thorough first aid treatment was administered. From there they were taken by ambulance to a field or an evacuation hospital where the first definitive treatment was given.

The 9th Evacuation Hospital, the nucleus of which came from Roosevelt Hospital, New York City, had from 750 to 900 cots set up under ward tents which permitted from 20 to 22 cots to a tent. For diagnosis and treatment the organization was departmentalized into the laboratory, x-ray, pharmacy, dental, minor surgery and operating room sections and shock, postoperative and preoperative wards, besides the general wards. Administratively, there were a headquarters' section, supply, utilities and transportation section and a mess section. The last was comprised of cooks, cooks' helpers, butchers and bakers, a mess officer in charge of the section and a dietitian.

Operated Three Kitchens

The mess section operated three separate kitchens, one for officers, one for enlisted men and one for patients. Depending upon the layout of the hospital, which was determined by the shape and size of the field on which it was set up, the kitchens were sometimes located adjacent to each other and sometimes at opposite ends of the bivouac area. Each had its own personnel and each had its own distinctive procedure.

The mess equipment could be classified generally as standard field, local or improvised. The standard field equipment had to be designed so as to be light enough for carrying and loading aboard trucks during movement of the hospital, and yet sturdy enough to withstand the rough treatment it invariably received.

The main piece of equipment was the field range, which had a cabinet-like exterior approximately 4 feet high, 2½ feet long and 2 feet wide. At the base of the cabinet was an opening into which fitted a fire unit that provided the heat. The fire unit consisted mainly of a large burner and two tanks, one for gasoline and the other for air, compressed by a tire pump, which, when mixed correctly with the gasoline, produced a very hot flame.

The field range came equipped with a 10 and a 15 gallon stock pot, a bake pan with a cover which, when inverted, could be utilized as a grid-

Presented before the New Jersey State Dietetic Association, April 1946.

dle, and the usual forks, ladles and strainers so useful in a kitchen. The hospital had 18 such field ranges.

Another useful piece of equipment was the water heater case, a square metal case encompassing a fire unit, which served as a base for heating water and for open kettle cooking. Water storage tanks were essential because water had to be hauled sometimes as much as 20 miles by tanker from an army water point where facilities were set up for chlorination. Even when the hospital utilized buildings, the water was usually nonpotable and not to be trusted.

Particularly convenient for diet preparation was a 20 man cooking outfit which was designed primarily for forward combat troops operating well in advance of their kitchens. It consisted of a small two burner kerosene stove with half gallon and quart pots, a coffee pot and a frying pan, which made preparation of small portions a simpler chore.

Cooking Equipment Found

As the hospital moved up the Rhone Valley into Alsace-Lorraine and across the Rhine into Germany, there were found for the first time suitable buildings which could be used as hospital facilities. Frequently, there was found in these buildings some such useful equipment as coal ranges, electric ovens, electric roasters, steam tables, potato peelers and vegetable slicers. What seemed to be a fairly standard piece in the foreign kitchens was a 150 gallon steam kettle heated by coal.

During the war we all marveled and were amused many times by the ingenuity of the American soldier. Stemming from a desire to do something just a little better, improvisations provided amusement as well as necessities. With the addition of iron plates, a field range could be made into a suitable oven and time and again remarkably delicious products were baked under such uncontrolled conditions.

Until we were forced to pull back from the path of the Germans pouring through Kasserine Pass in Africa and leave it behind, we had enjoyed our only source of baked goods, an old fashioned type of baker's oven constructed of discarded gasoline barrels halved lengthwise, with stone and mud for insulation.

The procurement of food and the utilization of the different types of rations gave the field hospital dietitian a real headache. Whereas civilian dietitians are accustomed to having their supplies delivered right to the kitchens, the army mess had to travel as much as 50 miles to a ration dump for its allowance.

The allowance was fixed at a certain quantity per hundred men and the menu to be served was determined by the quartermaster corps. Although the drawing of rations was supposed to work on a three day cycle, that is, rations drawn today would be used two days hence, the locality of the ration dump and the availability of transportation so affected the speed of delivery that menus could not be written more than a day in advance and at times not before the day of use.

The variety of the menu depended upon the type of rations that were issued, which were classified as K, D, C, B, A or 10-in-one, and upon the possibility of making authorized local purchases of fresh vegetables and fruits or of using local bakeries and ice cream plants, provided they were sanitary and not too heavily damaged by the fighting.

Perhaps an explanation of the components of the various rations would be interesting. The 10-in-one ration, which came in five different menus, was rarely issued to hospitals, because it was designed and packed as a day's fare for 10 men. Whenever the stock of the ration dump became so low that 10-in-ones had to be issued, it usually happened that no single menu was obtained at one time and there arose the problem of composing a menu suitable for several hundred.

K, D and C rations were designed for emergency use or when traveling and were packed for individual consumption. The K ration was contained in a carboard box, waxed for protection against moisture, about the size of a crackerjack box. Depending upon whether it was a breakfast, dinner or supper unit, it consisted of a small can of ham and eggs, pork loaf or cheese, two different kinds of crackers, an envelope of powdered coffee, cocoa or bouillon, a fruit bar, chocolate bar or compressed cereal, a stick of chewing gum and several cigarets.

The D ration was a solid enriched chocolate bar that could be carried in one's pocket as an emergency measure. The C ration consisted of two cans, each about the size of a peanut can. One contained either meat and beans, meat and vegetable stew or meat and vegetable hash and, later, spaghetti and wieners or chicken and noodles. The other contained four circular hard crackers, several hard candies and either powdered cocoa, soluble coffee or bouillon.

The main course of the C ration could be heated by letting the can stand in hot water a short while before opening, provided one had a source of hot water. One practical way of heating the ration when traveling by vehicle was to wedge the can against the hot engine block and stop for lunch about 10 miles farther up the road.

The B ration consisted of the same dishes found in the C rations but packed instead in No. 10 cans for more efficient serving of groups instead of individuals and was supplemented by a variety of canned fruits and vegetables.

A Ration Was Best

The field A ration, when available, really made life worth living for our dietitian for this consisted of fresh meats, fruits, vegetables, butter and eggs. Delivery to the forward areas of fresh items depended upon refrigeration facilities and the amount of transportation that could be allocated to their shipment. Every effort was made to ship fresh foods when possible because of the substantial effect they had on morale.

Food for therapeutic diets was usually limited and more often than not unobtainable. At times, however, there were three types of supplements for this purpose, only one of which was issued at any one time. These included a hospital supplement packed for emergency use which contained sugar, coffee, condensed and powdered milk, fruit and fruit juice; a requisitioned supplement based upon a monetary allowance per patient, and a set list of foods issued on the basis of the patients' strength.

To serve diets that were suitable to the patients' needs and in an appetizing manner required considerable maneuvering and was not always done with success. Ulcer diets were prepared with powdered eggs and canned or powdered milk; low fat diets had to be made with only canned meats and no skim milk; liquid diets were concocted with only canned or powdered milk and lim-

ited quantities of fruit juices; no gelatin desserts or ice cream and no ice to make beverages palatable were available. Despite these trials, the patients received the best possible consideration under the circumstances.

The problems of transporting food to the patients varied with the terrain on which the hospital was located and with the weather. In nice weather patients who were ambulatory walked to the kitchen and were served "chow-line" fashion. Collapsible tables and benches were set up in a ward tent for a dining room and there were more tables and benches outside under an awning of canvas for those who, despite the life they were leading, still liked the outdoors.

In the early months of the war patients used enamelware plates, cups and saucers, which came packed in a wooden chest that contained enough utensils for 100 men. Later we were able to obtain both metal and plastic compartmented trays, which simplified serving, washing and handling by the patients.

For those unable to leave their wards the food was transported to them in food cabinets, an insulated metal box 2 feet long, 1½ feet wide and 1½ feet high, with handles on each end for carrying. Each cabinet had six tin or aluminum inserts which would hold enough food for 50 patients.

Service Somewhat Cramped

When loaded with food the cabinets were usually too heavy for even two men to carry any distance and were transported to the ward entrance by vehicle. Serving was slowed considerably in bad weather for the muddy footing was treacherous and, with all patients staying in their wards and the tent openings battened down, the room available for dishing out was cramped.

Following closely as it did in the wake of the fighting, an evacuation hospital had to be prepared to evacuate its patients, tear down the hospital, move to a new location and begin operation again. This performance was repeated 25 times in thirty-five months in our outfit, an average of once every five weeks. In one area the hospital was set up, patients were treated and the hospital was torn down and moved on all in five days. As a result, the patient census was never stable and to find several hundred new patients at a meal was not unusual.

In Southern France, after a forward movement of 234 miles, the hospital admitted 578 patients in the first thirty hours after driving the first peg in the ground, and the census kept rising to almost 1200 before the load slackened. Rainy weather often flooded the kitchens, leaving the flooring a thick sea of mud which became even more treacherous as it hardened and became slippery. Dry and windy weather blew sand and dust under the tents and into the food and warm weather brought flies and insects that increased the need for sanitary measures.

At the end of her day of coping with all these problems, our dietitian could retire to her small wall tent, which covered a piece of ground 9 by 9 feet square. She shared this with a nurse and by the time each had set up her cot, fixed over an old ration crate with crinoline and red flannel bandage as a dressing table and tucked in a couple of suitcases at the foot of the cot there was hardly enough room left for them both to turn around. If she was able to get some old cardboard, a piece of salvaged canvas or a straw mat, she could keep her feet off the bare ground.

A few alterations of a mattress cover made a suitable garment bag to keep the dust off clothes hanging from a canvas strap tied to the tent poles, and the dietitian appreciated her helmet all the more when it came to doing her stockings and undies. When the weather turned cold a pressure kerosene stove or an oil burning stove she had bartered for with some native helped drive the chill and dampness from her tent, and when the weather was hot she sweltered at night under mosquito netting to reduce the possibility of getting malaria.

And now, after proving by her stamina and devotion to duty that her specialty has a place in our complex military organization, the dietitian has come back to fall in step with her colleagues who had their own problems in civilian hospitals during the war. Do you suppose that because butter is a little scarcer now, because bread is a few shades darker or because equipment is difficult to obtain she will worry very much?

Tests Help in Teaching

THE time-honored case study method for teaching dietetics to student nurses was a long way from satisfying the needs of St. Mary's Hospital, Quincy, Ill., in the opinion of Alene Norton, dietitian, and Estelle Naes, clinical coordinator and instructor.

Together, Miss Norton and Miss Naes worked out a new system, which they have found valuable, so valuable, in fact, that Miss Naes has introduced it into other services in the St. Mary's Hospital School of Nursing.

The first step of the plan is a pre-test designed to cover factual material, mastery of which is deemed necessary to entrance into the diet kitchen phase of nursing education. The test is given to the students on their first day in the diet kitchen.

Results are tabulated and discussed with each student. She then knows which points she has already mastered and with which points she needs assistance and experience. These items are kept in mind during the entire period the student nurse spends on the service.

At the end of their six weeks in the diet kitchen, the students are given a comprehensive examination. The results give the dietitian a check on her work. Has she given the student the experience she needs in the diet kitchen? Did the student derive from the work those facts and experiences she desires?

Copies of both the St. Mary's diet kitchen pre-test and the comprehensive examination following diet kitchen service are given on page 104.

PRE-TEST AND COMPREHENSIVE EXAMINATION FOR STUDENT NURSES

DIET KITCHEN PRE-TEST FOR STUDENT NURSES

NAME _____

DATE _____

1. Name the standard hospital diets.
2. Give the modifications of a regular diet necessary for making it a soft diet.
3. Name the foods that form the basis of the normal diet. Give the recommended daily servings of each group.
4. Give the characteristics of a bland diet.
5. Ulcer diets are modifications of the ..... diet.
6. What modification of fat is necessary in each of these gastric conditions?
   Hyperacidity
   Gastric atony
7. What principles of diet therapy are involved in the use of a Sippy diet for ulcers.
8. Name the types of constipation and the residue modification for each.
9. a. Why is protein intake kept low in diet for liver damage?
   b. Why is fat content low?
   c. Why is carbohydrate content high?
10. Write a diet order for each of the following conditions:
    a. Gallbladder malfunction
    b. Anemia
    c. Hypo-acidity
    d. Hyperthyroidism
    e. Tuberculosis
    f. Avitaminosis
    g. Severe Cardiac Disease
11. Cookery principles:
    a. Give procedure for poaching an egg.
    b. Give steps in sectioning a grapefruit.
    c. Standard products are those products possessing the characteristics that show them to be carefully and properly prepared. Give characteristics of a standard product of each:
       Stewed prunes
       White sauce
       Poached egg
       Steak
       Fresh fruit salad
    d. Give steps in preparing white sauce for creamed carrots.
    e. Give five *different* ways of serving each of the following.
       Potatoes
       Eggs
12. Diabetics
    a. Name five foods to be avoided on a diabetic menu.
    b. Name five foods that can be given on a diabetic menu without calculating those having no food value.
    c. Fruits and vegetables are classified according to _____ content.
    d. Write a diet order for a man weighing 154 pounds (ideal weight) and requiring 1½ gms. carbohydrate to 1 gm. fat.
       P_____ F_____ CHO_____ CAL_____

COMPREHENSIVE EXAMINATION GIVEN STUDENT NURSES AFTER SERVICE IN DIET KITCHEN

NAME _____

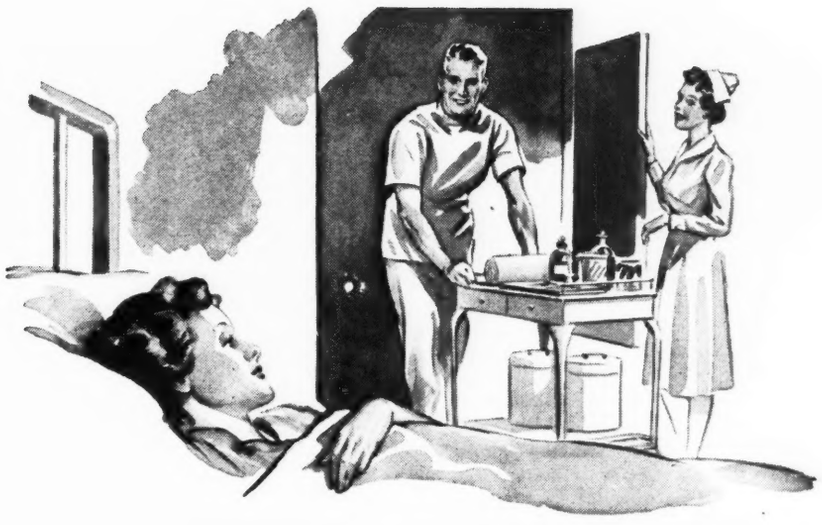
DATE _____

1. Name the two principles of menu planning.
2. Give four methods of obtaining variety in the menu.
3. Check the foods *to avoid* on a soft bland diet.

_____a. Tomato juice	_____i. Gelatin dessert
_____b. Coffee	_____j. Brussels sprouts
_____c. White bread	_____k. Roast pork
_____d. Fried potatoes	_____l. Baked potato
_____e. Chicken	_____m. Creamed eggs
_____f. Coleslaw	_____n. Fish
_____g. Harvard beets	_____o. Carrot puree
_____h. Milk	_____p. Ice cream

4. Give four modifications of a regular diet necessary to fulfill an order for a high calorie soft diet.
5. The Sippy diet is used for _____. The gradual increasing of the Sippy diet to a convalescent bland diet requires about _____ days.
6. What modifications would you make in the diet of a diabetic who complains of diarrhea?
7. A nonresidue diet excludes what valuable liquid goods?
8. What modifications of diet are necessary for the severe cardiac patient?
9. Name five examples of foods that must be avoided in planning a cardiac menu.
10. Give five foods that would be eliminated on a fat free diet. Name five foods that could be used as substitutes.
11. Name four conditions that require modification of the fat content of the diet.
12. What pathological condition is indicated by each of the following diet orders:
    1. High CHO, Low fat, Low protein
    2. Muelengraeht
    3. High residue regular
    4. Salt free, restricted liquid soft
    5. Fat free soft bland
13. A reduction diet is adequate in all food essentials except _____
14. Cookery Principles:
    1. Give the preferred method of preparing scrambled eggs. Why is this method used in diet kitchen?
    2. How much time do you allow for soft-cooked eggs?
    3. Give the correct procedure for preparing farina.
    4. Why do we scald the milk in preparing baked custards?
    5. Give the proportions of flour to milk for:
       Flour_____ Milk_____
       Thin white sauce
       Medium white sauce
       Thick white sauce
    6. Give the thickening agent used in each:
       Custards
       Chocolate pudding
       White sauce
15. Diabetics:
    1. Give an average diabetic diet order for a woman of average size. P_____F_____C_____
       Calories_____
    2. Give the recipe for diabetic custards.
    3. Name five foods without food value that can be included on a diabetic menu without calculating.
    4. Complete the following substitutions:
       1 egg = _____ meat
       1 tsp. butter = _____ bacon
       1 tsp. butter = _____ mayonnaise
       100 gm. meat = _____ gm. fish
       60 gm. meat = _____ oz. meat
       100 gm. grapefruit juice = _____ gm. orange juice
       100 gm. tomatoes = _____ gm. carrots
       1 slice white bread = _____ gm. orange juice
       1 slice whole wheat bread = _____ cups cereal
       100 gm. 8% fruit = _____ gm. 12% fruit
    5. Write a diet order and one day's menu for a diabetic weighing 154 pounds (ideal weight) and requiring a carbohydrate/fat ratio of 1½ gm./1 gm. The patient is getting regular insulin, 10 units t.i.d.

		P	F	CHO
Egg	one	6	6	—
Bread	one slice	3	—	15
Cereal	½ cup	3	—	15
Milk	100 gm.	3	4	5
Meat	100 gm.	20	15	—
Bacon	3 strips	1	10	—
Cream	100 gm.	3	20	4
Butter	1 pat	—	9	—



ALL THE NUTRIENTS

Essential for a Food Supplement

Because of the recognized relationship between rapid postsurgical recovery and satisfaction of metabolic requirements, modern nutritional practice advocates postoperative feeding as early as possible. As a component of the postsurgical dietary, the delicious food drink which results from mixing Ovaltine with milk offers many nutritional advantages. Palatable and refreshing in taste, it can be given as soon as nutrient liquids are tolerated, and usually proves acceptable though other foods may be refused.

This delightful food supplement supplies a wealth of essential nutrients required in the recovery and healing processes—biologically adequate protein, readily utilized carbohydrate, easily emulsified fat, essential B complex and other vitamins including ascorbic acid, and necessary minerals. Thus it provides all the nutrients considered essential, in easily assimilated form, a factor of particular importance in abdominal surgery. Few dietary supplements can equal this food drink for early postoperative feeding.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk*, provide:

CALORIES	669	VITAMIN A	3000 I.U.
PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
FAT	31.5 Gm.	RIBOFLAVIN	1.50 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.81 mg.
CALCIUM	1.12 Gm.	VITAMIN C	39.6 mg.
PHOSPHORUS	0.939 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

***Based on average reported values for milk.**

Menus for September 1946

Henrietta Kamarit
Culver Hospital
Crawfordsville, Ind.

1
Cantaloupe
Coffee Cake, Bacon Strips
•
Shrimp Cocktail
Skillet Smothered Chicken
Whipped Potatoes
Buttered Cauliflower
Molded Vegetable Salad
Red Raspberry Sundae
•
Cream of Mushroom Soup
Veal Sa'ad
Tomato Slices
Buttered Wax Beans
Fruit Plate of Grapes, Philadelphia Cheese, Fresh Apricots, Crackers

2
Stewed Apricots
Scrambled Eggs
•
Roast Pork, Apples
Grilled Sweet Potatoes
Buttered Green Asparagus
Lettuce Hearts With Chiffonade Dressing
Fresh Pineapple
Chocolate Stick Cookies
•
Vegetables in Broth
Escalloped Sweetbreads
Buttered Spinach, Lemon
Golden Glow Salad
White Cake With Coconut Filling

3
Sliced Bananas
Bacon Strips
•
Swiss Steak
New England Boiled Potatoes, Onions and Carrots
Pickled Beet Salad
Apple Dumplings With Nutmeg Sauce
•
Cream of Tomato Soup
Macaroni and Cheese
Cutlets
Broccoli With Hollandaise Sauce
Mixed Fruit Salad
Butterscotch Ice Cream

4
Blended Fruit Juice
Soft Cooked Eggs
•
Ham Loaf
Escalloped Potatoes
Buttered Green Beans
Stuffed Tomato Salad
Fresh Peach Shortcake With Whipped Cream
•
Cream of Pea Soup
Lamb Chops With Mushrooms on Toast
Corn on the Cob
Combination Salad
Molded Pear Half With Whipped Cream

5
Sliced Oranges
Scrambled Eggs
•
Broiled Liver and Bacon
Parsley Buttered Potatoes
French Fried Onions
Cabbage Relish in Gelatin
Fresh Applesauce
Drop Cookies
•
Consommé Julienne
Egg Croquettes With Parsley Sauce
Buttered Asparagus Tips
Grapefruit and Maraschino Cherry Salad
Chocolate Eclairs

6
Fresh Sliced Peaches
Crisp Bacon
•
Salmon Patties With Tartare Sauce
Potatoes on Half Shell
Creamed Peas
Tossed Vegetable Salad
Fluffy Lemon Pie
•
Oyster Stew
Molded Pineapple and Cheese Salad
Toasted Buttered Raisin Bread
Chilled Tomato Juice
Vanilla Ice Cream

7
Stewed Prunes
Cinnamon Rolls
•
Broiled Cubed Steaks
Baked French Fries
Lima Beans in Cream
Apricot Salad
Date Pudding With Whipped Cream
•
Noodle Soup
Veal Patties With Bacon
Sautéed Apple Rings
Lettuce Salad With 1000 Island Dressing
Toasted Snow Squares With Butter Sauce

8
Half Grapefruit
Poached Eggs
•
Spiced Fruit Juice
Roast Capon With Savory Dressing
Mashed Potatoes With Giblet Gravy
Buttered Brussels Sprouts
Cranberry, Orange Salad
Pecan Ice Cream
•
Cream of Celery Soup
Ham, Chicken and Tomato Sandwich Loaf
Potato Chips
Frozen Peas
Orange Ambrosia

9
Figs
Bacon Strips
•
Rib Roast of Beef
Yorkshire Pudding
Buttered Kale
Pear and Coconut Salad With Fruit Salad Dressing
Butter Iced Spice Cake
•
Rice Broth
Ham à la King in Toast Cups
Buttered Wax Beans
Cheese Stuffed Celery
Whipped Gelatin With Cream

10
Orange Juice
Omelet
•
Sautéed Veal Chops
Pan-Browned Potato Halves
Cauliflower in Cream
Waldorf Salad
Custard Tarts
•
Parsley Potato Soup
Baked Stuffed Tomatoes
Eggplant Strips
Lettuce Hearts With French Dressing
Fruit Cup and Macaroons

11
Prune Plums
Pecan Rolls
•
Meat Puffs in Mushroom Gravy
Riced Potatoes
Baked Acorn Squash
Garden Salad
Cherry Pudding With Whipped Cream
•
Corn Chowder
Cottage Cheese and Fruit Plate
Date Bread
Frozen Peas
Vanilla Mousse

12
Grapefruit Segments
Broiled Bacon
•
Baked Ham Slices With Fruit Cockail Sauce
Baked Sweet Potatoes
Buttered Fresh Spinach With Lemon Wedges
Sliced Tomato and Lettuce Salad With Russian Dressing
Raspberry Ice
•
Cream of Tomato Soup
Chicken Pinwheels
Buttered Green Beans
Relish Plate
Fresh Sliced Peaches
Angel Food Cake

13
Stewed Apples
Scrambled Eggs, Bacon
•
Baked Fish Fillets With Tartare Sauce
Creamed Potatoes
Green Asparagus Tips
Grapefruit and Orange Salad
Brownie à la Mode
•
Vegetable Soup
Hot Stuffed Eggs With Cheese Sauce
Jellied Pear Salad
Crumb Pudding With Cream

14
Pineapple Juice
Soft Cooked Eggs
•
Pan-Broiled Lamb Chops With Orange Slices
Parslied Potato Balls
Peas in Cream
Lettuce Salad With Tomato and Cucumber Dressing
Blueberry Pie
•
Cream of Asparagus Soup
Cold Sliced Ham, Cream Cheese
Potato Salad With Tomato Slices
Frozen Caramel Russe

15
Orange Sections
Coffee Cake
•
Grapefruit Halves With Cranberry Ice
Chicken Pie
Buttered Broccoli
Celery Hearts, Olives and Radishes on Lettuce
Toffee Sundae
•
Chicken Rice Broth
Sweetbreads à la Newburg
Buttered Asparagus
Spring Salad
Fresh Pineapple and Drop Cookies

16
Stewed Apricots
Poached Eggs
•
Sliced Baked Beef Heart With Gravy
Celery Dressing
Green Beans
Peach and Philadelphia Cheese Salad
Chocolate Pudding
•
Cream of Potato Soup
Canadian Bacon
Scrambled Eggs
Cinnamon Toast
Marshmallow Fruit Gelatin

17
Date Bread Toast
Grapefruit Juice
•
Danish Beef Steak
Baked Potatoes
Frozen Corn in Cream
Spinach Salad With Hard Cooked Egg Slices
Orange Mallow
•
Cream of Tomato Soup
Tuna Salad, Crisp Crackers
Buttered Asparagus
Cheese Stuffed Celery
Meringue Pears

18
Sliced Bananas
Crisp Bacon
•
Breaded Veal Cutlets
Escalloped Potatoes
Carrots and Celery
Lettuce Salad
Applesauce Cake With Whipped Cream
•
Noodle Soup
Chicken Salad in Tomato Cups
Frozen Limas in Cream
Fresh Pineapple, Vanilla Wafers

19
Figs
Coddled Eggs
•
Baked Virginia Ham
Buttered New Green Beans and Potatoes
Tomato Wedges on Lettuce
Cake Crumb Pudding With Fresh Peaches
•
Vegetables in Broth
Baked Stuffed Potatoes With Cheese
Buttered Broccoli
Fruit Gelatin Salad
Raspberry Ice

20
Half Grapefruit
Scrambled Eggs, Bacon
•
Oysters en Brochette Chili Sauce
Buttered Potato Slices
Peas in Cream
Orange and Maraschino Cherry Salad
Cream Tarts
•
Cream of Pea Soup
Mushroom Cutlets With Parsley Sauce
Buttered Spinach
Apple and Celery Salad
Butterscotch Pudding

21
Stewed Prunes
Bacon Strips
•
Chicken and Noodles
Frozen Asparagus
Molded Pineapple Nut Salad
Angel Food Cake With Caramel Icing
•
Cream of Asparagus Soup
Cottage Cheese and Tomato Salad
Graham Bread Sandwiches
Frozen Corn in Cream
Fresh Pineapple Sundae

22
Blended Fruit Juice
French Toast
•
Spiced Tomato Juice
Filet Mignon With Mushroom Caps
Stuffed Potatoes
Green Limas in Cream
Spring Salad
Strawberry Ice Cream Roll
•
Chicken Rice Soup
Toasted Bacon Sandwiches
Celery and Olives
Buttered Broccoli
Fruit Cup and Cookies

23
Fresh Applesauce
Shirred Eggs
•
Ham Loaf
Potato Cakes
Cauliflower in Cream
Lettuce Salad Topped With Shredded Carrots
Date Cake With Whipped Cream
•
Cream of Tomato Soup
Eggs à la King on Toast
Combination Salad
Apricot Ice

24
Orange Juice
Pecan Rolls
•
Crown Roast of Lamb With Currant-Mint Sauce
Creamed Potatoes
Buttered Peas
Grapefruit and Coconut Salad
Baked Custard
•
Consommé Julienne
Ham, Cheese and Celery Salad
Potato Chips
Chilled Tomato Juice
Cherry Pudding

25
Bacon Strips
Stewed Apricots
•
Baked Pork Tenderloin
Potatoes Martinique
Escalloped Cabbage
Spiced Red Apple Salad
Whipped Cream Cake
•
Cream of Mushroom Soup
Julienne Green Beans
Orange, Grape and Banana Salad
Buttered Pecan Ice Cream

26
Soft Cooked Eggs
Cherry Juice
•
Diced Steaks and Gravy
Browned Potatoes
Baked Onions With Pimiento Sauce
Mixed Vegetable Salad
Sliced Peaches, Cookies
•
Celery Bisque
Baked Stuffed Potato
Sautéed Eggplant Strips
Cheese & Pineapple Salad
Chocolate Cake

27
Bacon Strips
Stewed Fresh Pears
•
Baked Fresh Salmon
Paprika Julienne Potatoes
Buttered Whole Tomatoes
Lettuce Salad With 1000 Island Dressing
Lemon Roll
•
Cream of Potato Soup
Poached Eggs on Toast
Tossed Vegetable Salad
Apricots and Cookies

28
Sliced Bananas
Cinnamon Toast
•
Veal Bird Casserole
Whipped Potatoes
Cauliflower in Cream
Jellied Beet and Celery Salad
Dutch Apple Pie
•
Vegetables in Broth
Broiled Ham Slices
Green Limas in Cream
Celery Hearts and Olives
Strawberry Sundae

29
Tokay Grapes
Bacon, Poached Eggs
•
Consommé Madrilene
Creamed Chicken in Patty Shells
Frozen Peas
Tomato, Cucumber Salad
Black Cherry Sundae
•
Oyster Stew
Cheese Salad Sandwiches
Mixed Fruit Salad
Chilled Vegetable Juice
Whipped Gelatin

30
Orange Halves
Butterscotch Rolls
•
Beef Roast, Gravy
Franconia Potatoes
Parsley Creamed Carrots
Apple, Grapefruit Salad
Devil's Food Pudding
•
Chicken Broth With Rice
Creamed Ham and Eggs
Buttered Asparagus
Tomato and Endive Salad
Orange-Pineapple Ice Cream

Ready-to-eat or cooked cereals are offered on all breakfast menus.

Sunway BEVERAGE BASE

fortified with Vitamin B_1 and C

available in Orange, Lemon and Lime Flavors

12-Oz. Can Makes 4 Gallons of Beverage

This can when packed contained 7.69 GMS. of VITAMIN C (Ascorbic Acid) and .0649 GMS. VITAMIN B_1 (Thiamine Hydrochloride).

The FINISHED BEVERAGE, made according to directions on label, will contain 120 MGS. VITAMIN C, 1.0 MG. of VITAMIN B_1 and 116.3 CALORIES, TO EACH 8-OZ. GLASS.

This provides 100 and 400 per cent respectively of the adult minimum daily requirements for VITAMINS B_1 and C.

19 OUNCES of FRESH NATURAL, tree-ripened FRUIT JUICE was used in the making of this 12-ounce can of DEHYDRATED SUNWAY BEVERAGE BASE.

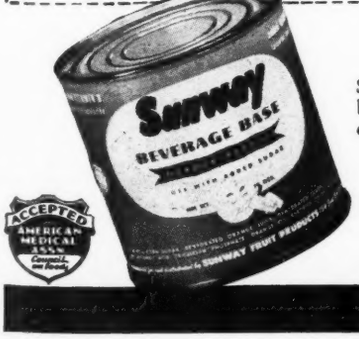
Sunway Beverage Base makes it possible to supply nutritious beverage juices at a moment's notice in hospitals, institutions, etc. A beverage base that furnishes high nutritional values of citrus juices and of ascorbic acid and thiamine hydrochloride . . . at a minimum of expense.

These delicious new dehydrated fruit juice flavors are developed by a new and exclusive process and are ***Easy to Prepare*** — just add water and sweeten.

So Economical to Use—One 12-ounce can of SUNWAY BEVERAGE BASE makes 4-gallons of true fruit beverage, and costs only $1.50. Cost of 8-oz. glass of "Sunway", including sugar is approximately 2½ cents.

★

If you have not tried SUNWAY BEVERAGE BASE, send for details today.



Sunway Beverage Base has been accepted by the Council on Foods and Nutrition of the American Medical Association.

SUNWAY Fruit Products

CHICAGO 11, ILLINOIS

PLANT OPERATION & MAINTENANCE

Meters Make the Steam Flow *Less Expensively*

T. JOSEPH HOGAN

Chief
Construction and Maintenance Section
Hospital Division
U. S. Public Health Service

THIS article is intended primarily to show the value of instruments in checking the performance of a boiler plant and maintaining peak efficiency under all operating conditions. It is often difficult for the hospital executive to see the connection between some new gadgets on the boilers and possible reduction in the operating cost, not to mention improved service and fewer operating troubles as an indirect result of the installation of a given instrument.

I became chief engineer of Buffalo General Hospital, Buffalo, N. Y., in February 1933 when the country was in the worst depths of the depression and most hospitals were drastically curtailing every item of expense. Under such circumstances our first move was to make every possible improvement that did not involve any material investment.

Failure Would Mean Disaster

There were a great number of obvious problems, but, to my mind, the most serious obstacle to improved service or economical operation was lack of instruments by which to operate the three 208 h.p. boilers. These three units were on the line and were being pushed to some extent. The lack of spare boiler power did not improve the situation. Here was a hospital in which failure of any equipment would be a catastrophe for we were operating an overloaded boiler plant without spare steam generating capacity for an emergency or for economical maintenance of the plant.

While I had not learned to fire with instruments, I had learned the almost impossible task of trying to fire intelligently without them. What could a new chief tell the firemen about firing these boilers, kept steaming by dint of hard, gruelling labor and constant attention?

There was, and still is, a recording steam pressure gauge in the engine room upon which the efficiency of the boiler was based at that time. Maintaining a constant steam pressure was the criterion of boiler performance and good workmanship.

This gauge was held in high esteem by both men and management and I found myself alone in not showing proper reverence and regard for its tale told in red ink each twenty-four hours of the day. My contention that it was an indicator of losses and not of efficiency branded me an iconoclast, trying to tear down the one thing that kept those men battling with coal, fire, bar, stoker and furnace all through their trick so that they might wash up, go to the engine room and pay homage to that red circle, proudly maintained.

Simple Improvements Cut Expenses. The time from February until the next heating season passed too quickly but some improvements had been accomplished, some had been partially completed and other possible improvements had been noted. Steam traps had been placed in advantageous points, old traps and reducing valves had been repaired or replaced and a start had been made in resizing steam branches.

The hospital was acutely aware of the depression and was further embarrassed by trying to maintain the high level of service it had educated the public to expect.

We went into the winter of 1933-34 with more confidence and, more important, with better control of steam distribution. Each winter saw better operation and less cause for concern in the boiler room. There was less and less cause to call upon the maintenance men to help clean a fire, or all fires, when the coal was not up to par or a fireman had become careless or negligent. It was still a three boiler job and required real work of the boiler room crew to maintain the steam for the demand.

Higher Efficiency Increases Plant Capacity. A new building of five stories was added in 1937-38. The boiler load had been decreased to a point at which it was possible to add this new load, including a new surgery of the most modern design, with its demands for high quality steam, without new boilers. The boiler load reached a new high but with better distribution and control it was not too severe.

It Was Flattering, but—

Repeated requests for metering equipment had been as often turned down. The hospital superintendent recognized the improvements that had been made and coal that had been saved. He was complimentary to his engineering department in his belief that the expenditure of $2000 for meters could not save money but only prove the efficiency at which we were operating.

The president of the hospital board was advised by an engineer of high repute that the expenditure could not be justified in an isolated plant al-

though at the time, 1934 and 1935, the hospital was consuming 4000 tons of coal annually:

Paid for in Six Months' Savings. The appropriation for the first meter was authorized early in 1938 and it was installed by our own men at a cost of $750. The second meter was installed in November and the third and last, in July 1939. The entire expenditure was paid for in coal saved in six months. There were and are other benefits which pay dividends daily.

The installation consisted of steam flow—air flow meters with a pen for recording stack temperatures. The meters are of the recording and integrating type by which the steam flow for any period can be read. Keeping the steam flow and air flow pens together gives a CO_2 reading of 12 per cent which gives best results for overall performance in this plant.

Furnace Maintenance Low

The furnace maintenance is kept at a minimum and the overall thermal efficiency is kept high. The stack temperature recorder completes the picture of the furnace and boiler performance and eliminates all guesswork in the management of the steam generating process.

The meters were not at first accepted by the firemen and it took drastic discipline to induce some of them to make any attempt to use them intelligently. Today, two of those firemen are engineers and wonder how a boiler plant can be operated without meters.

Comparative Performance Records. In February 1933 the boilers consumed 519 tons of coal and in February 1941 the tonnage consumed was 433, a saving of 86 tons. In 1932 the annual consumption was 4605 tons with 6540 degree days; in 1940 the tonnage was 3810 with 7509 degree days. This is an actual coal saving of 795 tons.

Adjusting for the greater number of degree days in 1940, the coal consumption in 1932 would have been 4882 tons. Allowing 150 tons per annum for heating and steam services in the new five story building built in 1938, with its 10 room surgery, and also the additional heat load entailed by new residents' quarters, the total saving in coal in 1940 over 1932 was 1222 tons, or $6415 for coal at $5.525 per ton.

Daily Record Is a Help

This saving for 1940 and the $1500 or $2000 that has been saved in each of the other years are not attributed to the meters only, but the permanent record of their daily or hourly story has helped us to accomplish much. Choice of coal has been dictated by the meters and mechanical changes and adjustments in stokers and furnaces have been confidently made on the basis of the information recorded. Cost of steam per thousand pounds is easily calculated and modernizations, made far from the source of supply of steam, can be justified by an accurate basis for calculation.

The present steam load is 220,000 pounds per day. The pounds of steam per degree day decreased each year as improvements were completed. In 1940 the total steam consumption was 65,671,210 pounds; in 1945 it was 55,835,488 pounds.

At a later date I should like to discuss other metering apparatus that has resulted in controlled heating in one of the largest buildings and which later was installed in two more sections of the hospital. This installation enables one of the boilers to carry the hospital steam load for 75 per cent of the time. This is a long stride from the three hard pressed boilers that served a smaller building area, equipment and census and is the result of careful planning and constant intelligent use of the daily records of the metering equipment.

The grade of solid fuel available has become progressively worse in the last two or three years. There is every indication that the higher grades of fuel burned so extravagantly in the past are no longer abundantly available. The limited supplies are being rationed to the special and highly technical uses of heavy industry.

Therefore, in any planning or budgeting program cognizance must be taken of the inferior quality, lower Btu. value, higher ash content and noncombustibles in the coal, as delivered. This inferior quality makes it almost imperative that the evaporation of water per pound of fuel be raised to the maximum. The cost of operation of any boiler that produces steam includes the cost of metering equipment, whether it is installed or not. It is better economic procedure to pay for metering once than to pay repeatedly for not having it.

The Need Is Unquestioned

There is no question about the necessity for a steam pressure gauge on a boiler. It would be just as sensible to generate steam without the aid of steam flow, air flow, CO_2 and stack temperature recorders as it would be to obscure the face of the pressure gauge.

Burning oil in the furnace of the steam generator might obviate some of the evils of coal, but oil has some specific inherent disadvantages of its own. Burners must be kept clean, oil temperatures must be maintained at an efficient degree and quality must be checked carefully. *The wasting of oil requires no manual labor.* Maintaining a predetermined steam pressure without the aid of metering equipment, when oil is issued as fuel, can become extremely extravagant without expenditure of effort on the part of the personnel.

The New Employe Needs to Know—

the background, policies and procedures that make the hospital and his job "tick"

FLORENCE DUBOIS MOOERS

Housekeeping Director, Sheppard and Enoch Pratt Hospital, Towson, Md.

SOME such conversation as the following might be heard almost any day in the housekeeping department of this hospital, and perhaps in others:

Housekeeper to New Porter: "Please go to B-1, room 10, and bring down that sort of rose-colored chair by the north—no, I think it's the west—window. You know the way. I showed you yesterday."

New Porter to Housekeeper: "Do I go this way and up those stairs there by that room—what did you say it's called?"

Housekeeper to New Porter: "No, no. You go to the right past the storeroom, on past the employes' cafeteria, turn right at the recreation room and go up the first stone steps you come to and . . ."

It is all too confusing and the new employe is so baffled that he cannot remember what his errand is, even if he should stumble onto the right path.

Doubtless we could and should do more, through printed diagrams, escorted tours and the practice of patience, to help the new recruit feel less lost in his new surroundings. But this is as nothing compared to the way we expect him to fit into the groove of his new job without our aid and understanding.

It is plainly the right of each new employe to be helped to feel at home and at one with his environment in the shortest possible time. A hospital is a particularly bewildering place to the uninitiated and there is much we can do to remove fears, flounderings and, sometimes, founderings, for it happens that some cannot find the courage to proceed on their lonely and untutored way and so just quit.

In the housekeeping department of our hospital it has been thought helpful to begin the process of orienting the new employe (after the necessary cards and records have been filled out and the physical examination is over) by sitting down with him and spending a few minutes in an effort to "sell" him the hospital and the niche he is to fill.

To this end a printed set of instructions is used, for something tangible in the hand helps to break the ice and fix the ideas. Before these are gone over, however, the

HOUSEKEEPING DEPARTMENT
REQUISITION

_____ 194____

Medical attention is requested for:

THINGS YOU WILL WANT TO KNOW ABOUT YOUR JOB AND THE HOSPITAL

Always keep in mind the fact that this hospital is here for the care and treatment of PATIENTS, and that whatever work you do is helping to accomplish this.

The aim of the housekeeping department is to keep the rooms, offices and corridors clean and attractive at all times, for the comfort and pleasure of all.

To do this in the best way certain rules of work and conduct are necessary, and the following points should be kept clearly in mind.

1. All tools and working equipment must be kept away from patients and brought back to the housekeeping office or put in your supply closet as soon as a job is finished.

2. Never open a door or do anything else a patient may ask you to do. In a polite way ask the patient to talk to the nurse or the doctor about it.

3. Do not carry on a conversation with patients. Be pleasant to them, but no more.

4. No employe can be called to the telephone during working hours, except in emergencies. Messages will be taken for you.

5. Working hours are from 7 a.m. to 12, and from 1 to 5 p.m. You are expected to be on the job promptly and to stay at it until time to leave.

6. Keep your uniform and clothing neat and tidy at all times, for your appearance is very important. Daily baths are advisable.

7. If you are sick, or injured in any way, report it at once to the housekeeping office.

8. No smoking while on duty or about the buildings will be permitted, except in your own rooms. Please think of the safety of others, as well as your own, and always be on the alert to prevent fires.

9. Your conduct when off duty is important. If you have pride in yourself, your job and the hospital you will be careful of what you do, as well as considerate of your co-workers.

10. Keep your bed neatly made and your personal things put away at all times. Regular inspections of your quarters are made.

11. Finally, be assured your personal happiness and welfare are of real importance here. If you have complaints or problems come in and talk them over. We will help you all we can.

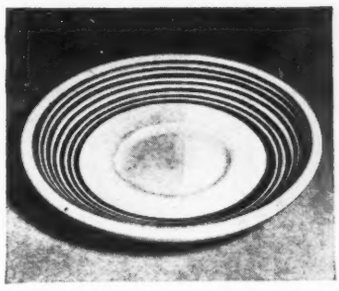
FLORENCE MOOERS
Housekeeping Director

FORMULA 6-66

FOR ALL DISHWASHING MACHINES

THOROUGHLY CLEANS CHINAWARE, GLASSWARE AND SILVERWARE. SAVES TIME AND LABOR.

FAST CLEANING — ECONOMICAL MAXIMUM RESULTS PROTECTS MACHINES.



One-half of this dish was dipped in a solution of Formula 6-66

Takes the stain, tarnish or discoloration off quickly! Scientifically blended for maximum results! Eliminates hand scouring! Keeps dishwashing machines free from scale, stains or mineral deposits.

Goes further and is most effective! Fast disposal of soil and grease! If Formula 6-66 is used from the start on new chinaware it will remain stain-free and its glaze intact. Formula 6-66 produces a low bacteria count.

FORMULA 5-55

WITH EXTRA SUDS

FOR HAND DISHWASHING

Harmless to the hands. A super-hand dishwashing compound, — replaces the finest soap powders, flakes and chips. Requires less compound and gives greater suds. Thoroughly cleans china, silver, glasses, utensils, woodwork, floors, tables and painted surfaces.

FOR INSTITUTIONAL LAUNDRY USE

MERCURY FORMULA 5
LAUNDRY DETERGENT

Magic of modern chemistry produced a detergent with a wide range of wetting, penetrating, lubricating high detergency with buffer action. A real money saver. Saves soap. More and tighter suds. Quick soil removing and free rinsing. Fabric life extended. More loads per wheel.

MERCURY FORMULA 10
COMPLETE LAUNDRY DETERGENT

Composed of the finest grade tallow soap, controlled alkalies, concentrated wetting agents, penetrating oils, and water conditioning chemicals. No caustic or uncontrolled harsh alkalies. Fast, safe, economical. Does not impair the tensile strength of the fabric washed and is free rinsing.

The Theobald Industries

MAKERS OF THE FAMOUS "MERCURY" INDUSTRIAL & INSTITUTIONAL CLEANERS & DETERGENTS

SOAP AND CHEMICAL DIVISION • P. O. BOX 72, HARRISON, N. J.

housekeeping director starts the discussion by telling the employe briefly something of the background of the hospital; its ancient and honorable purpose; the ideal of service to the distressed that was behind its founding; the standing it has in the eyes of the community, and the fine people who direct its affairs from behind the scenes.

Further, the housekeeper tells what the hospital has to offer the employe himself: the advantages there are in being employed in such an institution; the independence when working hours are over; the library facilities he is welcome to use; the good (or bad, alas) companionship that is there for him to choose or reject.

(Name of employe)

Housekeeping Director

YOUR VACATION NOTICE

_____ 194____

To_____

Two weeks' vacation is due you, beginning _____

On duty_____

F. Mooers

After this introduction, the opening paragraph of the printed instructions is read to the novice, while he follows on his own copy. It reads: "Always keep in mind the fact that this hospital is here for the care and treatment of the patients, and that whatever work you do is helping to accomplish this. . . . To do this in the best way certain rules of work and conduct are necessary and should be kept clearly in mind."

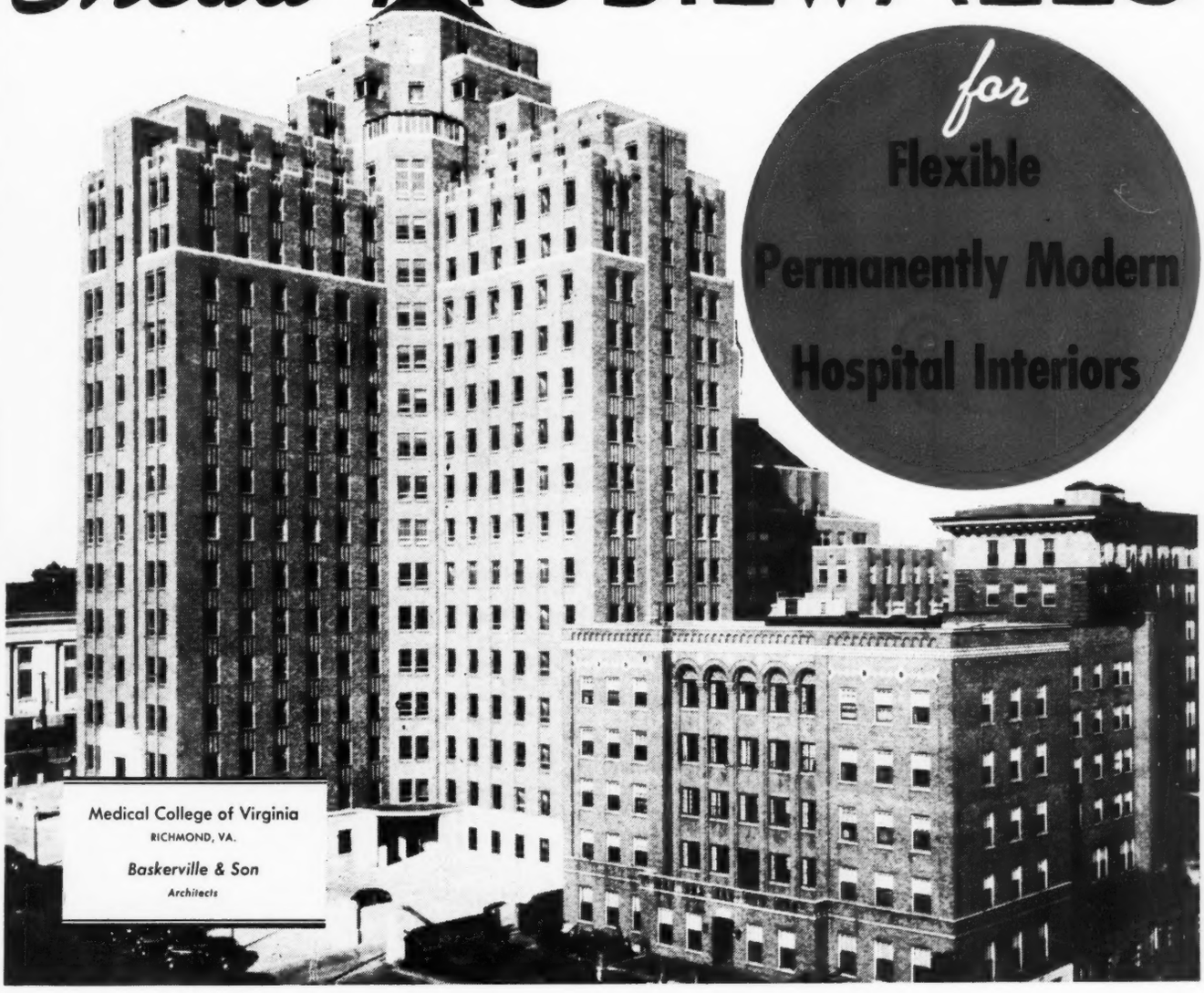
Then a review of the instructions begins. After each item has been read, as for example, this one: "Do not carry on a conversation with patients; be pleasant and courteous but no more," an explanation is given as to why experience has shown this procedure to be wise. If a good reason cannot be shown for the instructions we lay down, probably they are not wise and worthy of being observed.

Another reads: "All tools and working equipment must be kept away from patients and put in your supply closet as soon as a job is finished." In a psychiatric hospital the reason behind such a regulation is easily made clear and the failure to impress it on the mind of the new employe can mean the difference between life and death.

After the instructions have been explained, the employe is given an opportunity to ask questions or to express himself as he sees fit. Often he wants some point clarified. He is beginning to feel better acquainted now. This is going to be a good place to work. Why, he has even been assured that his welfare and happiness are of real consequence to this organization!

It is quite possible, even probable, that the orientation process has little effect on many employes. Nevertheless, it seems to be a step in the right direction and in some cases it may make the difference between a lost and unhappy "sheep" and an interested alert employe who sees point and purpose in what he is doing.

Snead MOBILWALLS



Baskerville & Son, architects who designed the Medical College of Virginia were cognizant of the everchanging needs of such an institution. Snead Semi-flush Mobilwalls and hollow metal doors were specified for corridors and dividing walls to secure maximum flexibility of interiors. Classrooms and laboratories can be enlarged or reduced quickly and easily without interruption of schedules and without dirt or muss. Snead Mobilwalls combine the permanent appearance, privacy, and soundproofness of fixed masonry walls with instant mobility and complete reusability of parts. With Snead Mobilwalls you build for the future as well as the present. Send for catalog and photographs of Snead hospital and institutional equipment.

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NEWS DIGEST

HOSPITAL BILL IS PASSED BY HOUSE

S. 191, the hospital survey and construction bill, passed the House of Representatives by an overwhelming majority July 27. The bill will now go to a conference committee to resolve differences between the House and Senate versions before it is sent to the President for signature. The bill passed by the House cut down the amounts of federal subsidy available to states and reduced the number of professional representatives on the eight man advisory council established in the Senate bill from five to four. **(See page 118.)**

CALIFORNIA HOSPITALS GIVE SALARY BOOST

The California Nurses' Association has completed an agreement with five hospitals in the Oakland-Alameda County area covering salaries and working hours for graduate staff nurses, George U. Wood, administrator of Peralta Hospital at Oakland, told The MODERN HOSPITAL July 23.

Under the agreement, graduate staff nurses at the five hospitals will be paid salaries starting at $200 a month and increasing $5 a month at six month intervals up to $215, with a $10 a month bonus for night duty and $10 for obstetrical service. All salaries will be paid in cash, the agreement stipulates. The working week for staff nurses will be reduced to forty-four hours on October 1 and to forty hours on Jan. 1, 1947.

The five hospitals with which the agreement was made are Peralta, Samuel Merritt, Alameda County and East Oakland at Oakland and Berkeley Hospital at Berkeley.

BARGAIN COUNTER X-RAY EQUIPMENT

Several high-voltage x-ray machines costing from $25,000 to $35,000 each have been placed on sale to educational and public health institutions by special order of the War Assets Administrator at 3 per cent of fair value. For purposes of resale, fair value has been defined as 60 per cent of acquisition cost. The order states that W.A.A. will give wide public notice of the availability of the machines. "As between claimants of the same class," it continues, "the machines shall be disposed of to those who in the opinion of W.A.A. can put them to the use most beneficial to the United States, and preference shall be given to their use for research, especially in the field of cancer."

NURSES TO GET PAID OFF — IN STAMPS

A bill providing for the issuance of a special postage stamp honoring the nursing profession was introduced in the House of Representatives recently by Congresswoman Rogers of Massachusetts. The bill would authorize the Postmaster General to issue a 3 cent stamp of special design "in commemoration of the invaluable contribution of nurses to the welfare of our people in community hospitals and in homes during times of peace and war, and of the sacrifices and heroic work of nurses in the armed forces."

BULK PENICILLIN NOW OVERSUPPLIED

Improvement of the mold strains from which penicillin is extracted has made possible the production of a greater supply of penicillin than it is possible to use in this country today, according to a release from the Civilian Production Administration, and bulk penicillin is now being exported. This does not mean, of course, that an adequate supply of penicillin for therapeutic use is available, it was pointed out. However, facilities for producing injectable penicillin from the mold extract are being used to capacity, and until more of the elaborate refrigeration and high-vacuum drying installations are made possible, the bulk volume cannot all be used here.

BED-DEATH RATIO IN HOSPITAL ESTIMATES

The number of hospital deaths bears a fairly constant ratio to occupied hospital beds in most areas and may provide a more accurate basis than is now available for estimating the need for beds, the Commission on Hospital Care has discovered. People use about 250 days of hospital care for each death in a general hospital, commission experts have figured out. By statistical wizardry, this fact is transformed into a bed-death ratio of .7, meaning that seven tenths of a hospital bed is used for each hospital death every year.

The percentage of deaths occurring in hospitals is a pretty good index of the adequacy of hospital facilities, it is argued. In some states this has reached 50 per cent, though it sags as low as 25 per cent or less in other areas. With 50 per cent or more of deaths in hospitals as a goal, the bed-death ratio may be used to estimate the needs of an area for additional hospital facilities.

This is a better method than figuring bed needs on crude population, the commission believes.

COLLEGES URGED TO AID NURSE DRIVE

Young women who are unable to enter college this fall because of the crowding of educational facilities and the educational housing shortage should be persuaded to turn instead to schools of nursing, the National Nursing Council and American Council on Education are urging in a joint communication to presidents of 600 colleges and universities across the country. A recent study by the National League of Nursing Education shows that 15,000 student nurse applicants have been accepted for fall classes, and 25,000 more are sought by the schools.

The joint letter to presidents pointed out the need for additional nurses and the advantages of nursing education as the basis for a career.

NEW SOCIETY TO AID MEDICAL RESEARCH

A National Society for Medical Research has been organized under the sponsorship of the Association of American Medical Colleges, with the cooperation of more than 100 national scientific organizations. The society will be a clearing house for information on medical studies and discoveries and has as its purpose the advancement of research in medicine, biology, pharmacy, dentistry and veterinary medicine, and the analysis and exposure of antivivisectionist propaganda. Dr. Anton J. Carlson, professor emeritus of physiology at the University of Chicago, is president of the society.

TONSILLECTOMIES TO BE DEFERRED

Following a death from bulbar poliomyelitis in Chicago July 8, Health Commissioner Herman N. Bundesen wired Chicago hospitals requesting that in the interest of public safety all tonsillectomies, adenoidectomies and other mouth surgery be deferred until after the polio season. This request is justified, in the opinion of Dr. Edwin P. Jordan, associate editor of the "Journal of the American Medical Association," because it has been demonstrated that these operations add materially to the hazard of acquiring polio.

S. 191 Passes House by Huge Majority; Amendments Reduce Amount of Aid

By EVA ADAMS CROSS

WASHINGTON, D. C.—The Hospital Survey and Construction Bill, S. 191, passed the House of Representatives by an overwhelming majority July 27. Conferences to resolve differences between the House and Senate versions were to be held immediately. The House bill had been favorably reported by the House Committee on Interstate and Foreign Commerce July 13, with amendments reducing the amount of federal aid.

The amendments reported by the committee are as follows: Under the Senate version, a state would have been entitled to receive federal funds equal to 50 per cent of its expenditures in carrying out the provisions of the bill relating to inventories of existing hospitals, surveys of the need for construction of hospitals and the development of programs for hospital construction. The amendment reduced the amount of the federal payment to 33⅓ per cent.

The Senate bill authorized an appropriation of $5,000,000 for surveys and planning of future construction; the committee cut this appropriation to $3,000,000.

Deleted by the House committee was the provision that when the governor of a state certified to the surgeon general that no funds were available for survey and planning, a federal loan or advance would be made in addition to the grant for such purposes.

The Senate approved bill provided that federal funds allotted to the states for construction should be available for payment of the state's "federal percentage" of the cost of approved construction projects in the state. Under the formula provided, the "federal percentage" in the case of a particular state would have been a percentage of not more than 75 per cent and not less than 33⅓ per cent, varying in proportion to the state's per capita income. Under the committee amendment, the federal share to be paid is fixed at 33⅓ per cent of the construction cost. In other words there is no variable grant for construction.

A change has been made also in the representation on the Federal Hospital Council. Formerly, five of the eight appointed members were to represent the professional field; three, the consumers. The House committee bill has changed this ratio to four and four.

In addition to changing the portion of the cost of a project which will be paid for with federal funds from a "federal percentage" to a flat 33⅓ per cent, the committee made two other changes in subsection (a) of the Senate bill. First, it adds to the requirement that the project application be recommended by the state agency, the requirement of approval of the application by the state agency. Second, it requires the surgeon general to give the state agency an opportunity for hearing before disapproving it instead of requiring a hearing for both the agency and the applicant.

The term "construction" is defined to include the construction of new buildings and the expansion, remodeling or alteration of existing buildings, and the initial equipment of any such building. It would include architect's fees but would exclude the cost of off-site improvements and, except in the case of public health centers, the cost of acquisition of land. The Senate bill included *landscaping the site of buildings and legal counsel* as part of the "construction" of hospitals. The committee has eliminated these items. The Senate bill also mentioned all other expenses incidental to construction as included in the definition. This, too, has been deleted in the House amendment.

Urge Eligible Hospitals to Apply for Discount Certificates

By EVA ADAMS CROSS

WASHINGTON, D. C.—The Office of Surplus Property Utilization, U. S. Public Health Service, is urging eligible hospitals to send in their applications for discount certificates, an official of this office said in an interview July 15. Application forms were mailed to 25,000 known eligible public health institutions July 1. In less than two weeks, more than 1000 of these applications had been properly filled in and returned.

The official said that though it is recognized that there will not be enough supplies for everyone, *some* items are available now at site sales and there will be more surplus available in the future.

The War Assets Administration, following a conference held here recently with a special American Hospital Association committee, has advised all regional directors of W.A.A. offices to keep eligible hospitals informed concerning available surplus property. Newspapers will be used increasingly to advertise site sales.

To qualify at site sales for a 40 per cent discount from the price to wholesalers, eligible health institutions will show a discount certificate issued by the Office of Surplus Property Utilization, U. S. Public Health Service. The certificate, valid indefinitely, will automatically ensure the discount. W.A.A. will use site sales more and more as a means of disposing of surplus property.

Blue Cross Enrollment Breaks Record in Second Quarter of 1946

Enrollment in the 87 Blue Cross plans totaled 1,773,250 for the first six months of 1946, bringing membership in these nonprofit hospital service associations to 23,132,508, the commission office announced July 26.

The second quarter gain was 403,197, more than the first quarter's. Growth for the first six months of the year was 3,143,313, within 335,000 of the membership gained during the entire year 1945.

Associated Hospital Service of New York headed the list, enrolling 190,777 during the second quarter, followed by the Blue Cross Plan for Hospital Care, Chicago, with 142,251, and Associated Hospital Service of Philadelphia with 85,622.

Four plans, New York City, Boston, Detroit and Chicago, now have more than a million members, and 14 plans have more than a half million. Wisconsin Blue Cross Plan moved into the 500,000 group by enrolling 67,150 members to bring its total membership to 516,800.

Among statewide plans, Hospital Service Corporation of Rhode Island continued to lead in percentage of population enrolled, its 432,033 members constituting 61 per cent of the residents. Group Hospital Service, Inc., Wilmington, Del., has 43 per cent of Delaware's population with 121,356 members, while Massachusetts Hospital Service covers 41 per cent of the state's population.

As of July 1, 17 per cent of the population of the United States and Puerto Rico were Blue Cross members, and 12 per cent of the Canadian populace. In other words, every sixth person in the U.S.A. and Puerto Rico and every eighth person in Canada are enrolled in Blue Cross associations.

Senators Sign Health Report

The most economical and efficient way to assure complete medical care for all is by a national compulsory health insurance plan, according to the report of a subcommittee of the Senate Committee on Education and Labor. Characterizing national health insurance as "simply a logical extension of private group health insurance plans to cover all the people," the report stated: "It will guarantee free choice of doctor or group of doctors and free choice of hospital by the patient, and free choice of patient by the doctor." The report was signed by Senators Pepper of Florida, Thomas of Utah, Murray of Montana and Aiken of Vermont. Members of the committee not signing the report were Taft of Ohio and Smith of New Jersey.

A.M.A. Delegates Approve Proposal to Set Up Public Relations Division

Creation of a special division of public relations and expansion of the activities of the bureau of medical economics were approved by the house of delegates of the American Medical Association on recommendation of the board of trustees at the association's annual meeting in San Francisco in July. Attendance at the session totaled nearly 8000, making it the largest medical meeting ever held on the Pacific Coast.

The new public relations division will be responsible for interpretation to the medical profession and the public of all the activities of the councils, bureaus and other agencies of the association. The division will be under the direction of an executive assistant to the general manager. The board of trustees was authorized to employ an outstanding expert in the field of public relations for this position.

Also to be employed is a leading economist to direct the expanded bureau of medical economics, whose function will now include the development of medical economics studies for publication in association periodicals.

As part of the anticipated shift in public relations activities within the association, the name of the council on medical service and public relations was changed to the council on medical service. This group will continue to promote the development of prepayment medical care plans but will have no public relations function henceforward.

Other actions of the house of delegates included approval of a resolution urging that the United Nations Health Organization restrict its activities to problems in preventive medicine and standardization of drugs and not concern itself with the nature of medical practice in member nations.

By action of the delegates, there will be two meetings of the house of delegates every year hereafter, instead of only one.

Dr. Anton J. Carlson, professor emeritus of physiology at the University of Chicago, was named recipient of the award of merit that is presented annually by the association.

The new public relations program was approved as a result of recommendations made by Raymond Rich, public relations counsel, who recently made a study of the public relations problems and activities of the association.

New Bill Proposes $35,000,000 District Medical Center

By EVA ADAMS CROSS

WASHINGTON, D. C.—The House of Representatives on July 22 passed the bill providing for a $35,000,000 federal medical center for the Washington area. The bill now goes back to the Senate for conference hearings.

The bill was presented by Alan Johnstone, general counsel for the Federal Works Agency. The program as outlined by Mr. Johnstone does not include some $5,000,000 in proposed expansion of the city's municipal hospital plants.

The F.W.A. representative explained that the bill was designed to make the following five point program effective.

1. Leave to the commissioners the orderly renovation and development of the public hospital plants in Washington.
2. Let Emergency, Garfield and Episcopal hospitals contribute to the proposed medical center in which they will participate.
3. Authorize federal grants to other Washington nonprofit hospitals for additions, renovations and replacements up to 50 per cent of their plants as improved.
4. Authorize the expenditure of federal funds over a five year period to accomplish these steps, charging 30 per cent of the amount expended to the District.
5. Let Congress determine the time and manner in which the District's percentage is to be paid.

The proposal calls for the District to contribute up to $10,500,000. The three participating hospitals of the medical center would contribute from 20 to 30 per cent of its cost; the federal government would pay the balance.

The program would give the District 5000 hospital beds. The present total is 3850. More than half of the present beds are in plants classified as obsolete, unsafe and insanitary.

Mental Health Act Is Law

WASHINGTON, D. C.—The National Mental Health Act became law July 3 with its signing by the President. The act sets up a federal research program to deal with mental illness and calls for the construction at Bethesda, Md., of a mental research center. The center will be a part of thhe National Institute of Health.

Littlejohn Heads W.A.A.

Maj. Gen. Robert M. Littlejohn was sworn in as War Assets Administrator July 22. General Littlejohn succeeds Lt. Gen. Edmund B. Gregory, administrator for the last five months, who retired because of ill health.

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High Voltage X-Ray Machines to Be Sold as Surplus Material

WASHINGTON, D. C.—Sale of government-owned surplus high voltage machines to eligible hospitals and similar institutions at 3 per cent of their fair value was authorized July 13 by the War Assets Administration. In disposing of the machines, W.A.A. will give preference to claimants who will use them for research, especially in the field of cancer. Various hospitals and universities have indicated interest in acquiring these x-ray machines for purposes of research and treatment.

Two million volt x-ray machines which cost the government between $25,000 and $35,000 have already been declared surplus. It is understood that expenses of reconverting them for medical purposes would run as high as $20,000, while the costs of a special concrete foundation, a lead-insulated chamber and other modifications necessary for installation, are estimated at from $15,000 to $50,000.

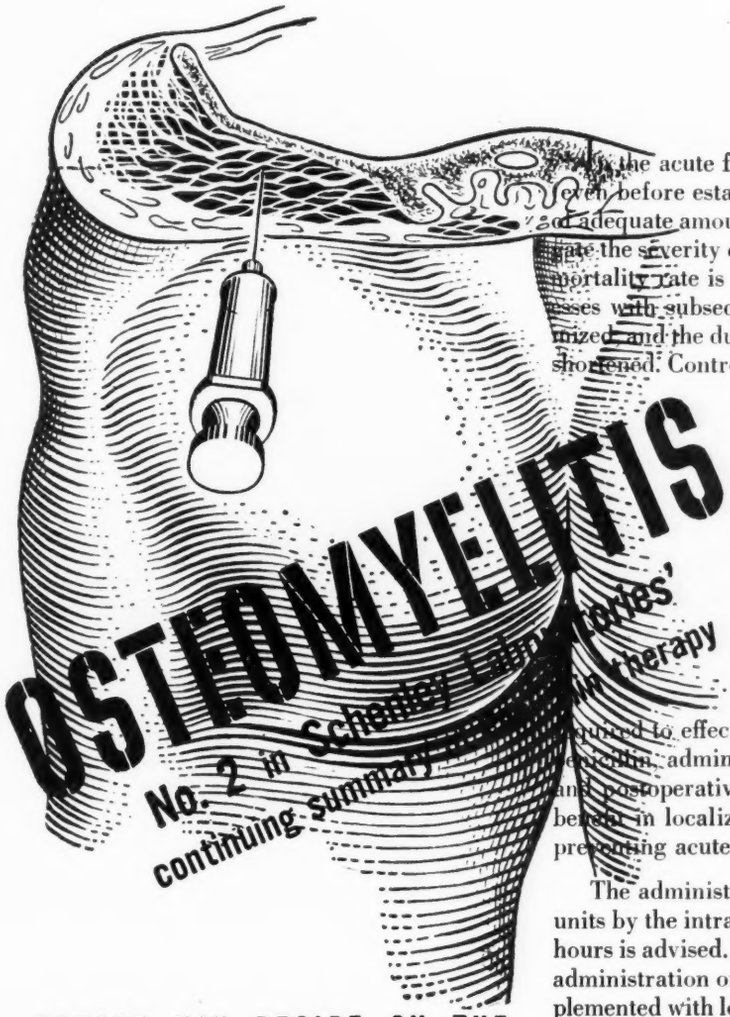
These supervoltage machines were originally used to detect flaws in iron and steel castings in industrial plants manufacturing tanks, boilers, turrets, flywheel gears and other war equipment and machinery.

Hospitals Train Polio Volunteers

Two New York hospitals, the Knickerbocker Hospital and the House of St. Giles the Cripple in Brooklyn, are training volunteers to assist physicians, nurses and physicial therapists in the care of infantile paralysis patients. Both of these projects are being sponsored by the Greater New York Chapter of the National Foundation for Infantile Paralysis.

For the last eight months Knickerbocker has been serving as a training center for polio care with some 30 beds devoted to patients suffering from this disease. The volunteer program started three months ago and, in consequence, some 50 volunteers ranging in age from 19 to 45 are now helping to feed and lift patients, make beds, apply hot packs and perform other attendant tasks. Three classes of approximately 10 volunteers have received twenty hours of demonstration and practice work. Members are expected to give eight hours of service weekly.

Another group whose members cannot take time to receive regular instruction are receiving training by actual work. Polio emergency volunteers serve when the need arises and are on call at all times. The volunteer program at the House of St. Giles has been organized more recently, and, in consequence, it has not completed a training course.



In the acute form, early administration (even before establishment of the diagnosis) of adequate amounts of penicillin will mitigate the severity of the infection. Hence, the mortality rate is reduced, destructive processes with subsequent deformity are minimized and the duration of the disease is shortened. Control and eradication of the infection may be obtained without major surgical intervention; however, surgical removal of necrotic bone will be required in some instances and abscesses should be either aspirated or incised and drained.

In the chronic form, major surgery is usually required to effect a cure; however, penicillin, administered both preoperatively and postoperatively, is of inestimable benefit in localizing the infection and preventing acute exacerbations.

The administration of 20,000 to 40,000 units by the intramuscular route every 2 to 4 hours is advised. When necessary, parenteral administration of penicillin should be supplemented with local instillations of 25,000 to 50,000 units in a sterile solution two to three times daily. Due attention must be paid to surgical, supportive, and other measures when these are indicated.

To determine complete control and eradication of the infection, a prolonged follow-up period with frequent physical examinations and serial roentgenograms is advised.

KEEFER, C. S. *Penicillin—Its Present Status in the Treatment of Infections: The Nathan Hatfield Lecture XXIX, Am. J. Med. Sc. 210:147 (Aug.) 1945.*

ALTEMEIER, W. A.: *Treatment of Acute Hematogenous Osteomyelitis with Penicillin, Ohio State M. J. 42:489 (May) 1946.*

BEFORE YOU DECIDE ON THE PENICILLIN OF YOUR CHOICE

For many years, Schenley has been among the world's largest users of research on mycology and fermentation processes. In addition, Schenley Laboratories manufactures a complete line of superior penicillin products—products thoroughly tested for potency and quality. These two important facts mean you may give your patients the full benefits of complete penicillin therapy.

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Asks Exemption of Government Trainees From Overtime Benefits

By EVA ADAMS CROSS

WASHINGTON, D. C.—The Federal Security Administrator asked Congress on July 13 to exempt certain interns, student nurses and other student employes of hospitals of the federal government from overtime and retirement benefits of the civil service laws. Administrator Watson B. Miller said that the plan had been worked out in cooperation with the District, the Budget Bureau and other federal officials.

Mr. Miller explained in presenting the proposed legislation that training standards in their professions require interns, student nurses and others to work more than the regular forty hour week. He said that it is not unusual for student employes to be engaged in study, practice or standby service in the hospitals for as long as eighty-four hours a week. Government hospitals in complying with the present pay laws either have paid the overtime rates or have limited the student-trainee work week to forty hours.

Under the proposed plan, student hospital employes' pay would be fixed by the controlling agency—maximum rates being fixed by the Civil Service Commission. The bill would bar such student employes not only from overtime pay but from benefits of the Civil Service Retirement Act and from the provisions of the annual and sick leave laws. Agency heads would determine the conditions of training, including sick leave and vacations with or without pay.

The bill would not affect the Cadet Nurse Training Corps or interfere with present authority of the administrator of the Veterans Administration. In local hospitals, about 75 student nurses and 40 interns at Gallinger would be affected; 150 student nurses and 40 interns at Freedmen's, and 100 student nurses and 12 interns at St. Elizabeth's.

New Law Strengthens V.A. Medical Program, Hawley Declares

WASHINGTON, D. C.—Almost 4000 additional doctors, dentists and nurses have been appointed to Veterans Administration hospital staffs since the first of the year, according to Dr. Paul R. Hawley. Public Law 293, enacted January 3, setting up a Department of Medicine and Surgery and offering doctors and nurses more attractive opportunities in V.A., has brought about this increase. More than 11,000 of such professional personnel were on duty as of May 31.

During this same period, V.A. assigned 450 resident physicians to duty in its hospitals. There are also 302 doctors serving as part time consultants and 398 as part time attending men, or junior consultants. Both groups were directing the residents and ensuring that the V.A. medical program was reaching its goal of being second to none, Dr. Hawley said.

Of the 3354 physicians on duty with V.A. on May 31, 752 were medical personnel lent by the armed services. The remaining 2602 were civilian doctors.

Although the Veterans Administration has virtually doubled its medical staff in the last six months, V.A. still needs physicians for its tuberculosis and neuropsychiatric hospitals, Dr. Hawley asserted. The need is most acute in the Southern and Western states. Approximately 7000 tuberculosis patients in army and navy hospitals are scheduled for transfer to V.A. as soon as adequate staffs can be found.

Makes Grants for Research

For special medical research projects in universities, hospitals and foundations, Winthrop Chemical Company, Inc., has made grants to a total of $92,500 in 1945-46, it is reported by the National Research Council. Largest single grant is for the study of tuberculosis.

Physicians Trained in Army, Navy Programs Assigned to V. A. Hospitals

WASHINGTON, D. C.—Approximately 1250 young doctors who recently completed their internships under the army specialized training program and the navy V-12 program were assigned to Veterans Administration hospitals July 3 and 10.

Under a program worked out jointly by the army, navy and V.A., these physicians have been assigned to V.A. hospitals to fulfill their obligations for two years of military duty after completing their internships. An additional 250 doctors from the navy will report before September.

While serving their two years, the doctors will be on military duty. A brief indoctrination program is planned so that the physicians will be familiar with V.A. procedures and their responsibilities to veterans. Each young officer will be attached to an experienced full time staff physician who will serve as a preceptor. Only a few of the new doctors are being assigned to those hospitals where V.A. is cooperating with Class A medical schools in setting up a residency program under the schools' "Dean's Committees."

Illinois Hospitals Cooperate With V.A. on Home Town Care

An arrangement is being made with the Veterans Administration for home town care of veterans in Illinois, Edson P. Lichty, executive director of Plan for Hospital Care, Chicago, told The MODERN HOSPITAL July 22. Under the proposed agreement Chicago Blue Cross will act as agent for hospitals all over the state, Mr. Lichty said. The plan is similar to the one which has been in operation for several months in Michigan, it was explained, and has been worked out with representatives of the Illinois Hospital Association.

Under an agreement recently made between the Veterans Administration and the Illinois State Medical Society, veterans are now receiving home town medical care for service-connected disabilities throughout the state.

29 States to Provide Prescription Service to Veterans, V.A. Says

Twenty-nine states have agreed to cooperate with the Veterans Administration in providing "home town" prescription service to veterans with service-connected disabilities, Dr. Paul R. Hawley, chief medical director, said today. The program was designed to reduce the reported delays which arose when all prescriptions had to be mailed to the nearest V.A. office and then sent to the veteran by mail.

Under the new project, eligible veterans simply take the prescription to their neighborhood drug store, and V.A. pays the bill.

Thirteen contracts with state pharmaceutical associations already have been approved, 12 others are pending V.A. approval and four other state drug associations have notified the Veterans Administration that they will negotiate contracts for druggists in their states.

Navy Nurses at Bikini

WASHINGTON, D. C.—Thirty-six members of the Navy Nurse Corps are with the fleet during its history-making experiment, Operation Crossroads, at Bikini, Capt. Nellie Jane Dewitt, superintendent, Navy Nurse Corps, said July 16. The nurses are aboard two hospital ships, the *U.S.S. Bountiful* and the *U.S.S. Benevolence.*

For the Thinking Hand . . .

Obedient instruments of the mind, the surgeon's hands—keen, quick, knowing—must think as well as act. In their unceasing battle to conquer and cure, those thinking hands deserve the double guarantors of "surgical security"—anatomically correct fit and tactile sensitivity.

Of resilient, pure natural rubber, SEAMLESS Standard Surgeons' Gloves are proportioned for perfect coordination with muscle movement. Uniformly thin, they flex sensitively with "thinking" and "seeing" fingertips. Brown Milled—banded, White Latex, Brown Latex . . . available through better Hospital Supply Dealers. *The Seamless Rubber Company, Surgical Rubber Division, New Haven 3, Conn. . . . finest quality since 1877.*

SEAMLESS Standard SR SURGEONS' GLOVES

Higher Pay Scales Slated for Nurses in Washington Hospitals

WASHINGTON, D. C.—Uniform and generally higher pay scales for nurses and other hospital personnel was one subject slated for discussion at the meeting of the new Washington Area Hospital Council here July 17. Meantime, as one way to beat the nurse shortage, a number of hospitals in Washington and vicinity have already raised salaries. Most of the hospitals in the metropolitan area are considering such action.

In line with the policy recommended by Dr. Claude W. Munger in his hospital survey for better cooperation among hospitals, hospital officials on an area-wide basis have been discussing informally the question of increased salaries for nurses and other hospital employes. One hospital mailed out to other hospital administrators a detailed statement of its entire pay scale in an advance notification of increased salaries.

Salary increases for nurses varied but at most hospitals here there is now in effect a minimum of $140 monthly plus meals and quarters and assurance of yearly increases. Garfield claimed that its operating costs were increased more than $100,000 a year through nurse pay increases.

Many hospitals consequently have raised rates or have announced impending rises. Doctors' Hospital on July 1 increased the rates of private and semiprivate rooms by approximately 5 per cent; Georgetown's rise on prices of private rooms went from $6 to $7 dollars a day, $7.50 rooms to $8.50 and $10 rooms to $12. Garfield upped the prices of $7 rooms to $8, of $12.50 rooms to $15. Freedmen's private rooms went from $4.50 to $7, semiprivate, from $4 to $6 and wards, $3.50 to $5.

It is understood that area hospitals will try to get a higher rate of payment from Group Hospitalization, Inc. A committee selected from trustees of Group Hospitalization is studying the possible revision of contracts with member hospitals. Subscribers to this organization have been assured that rising hospital rates will not reduce their hospital benefits. Joseph H. Himes, president of Group Hospitalization, said that if there is any increase in premiums it will be coupled with increased hospital benefits.

Higher pay for 36 jobs in Gallinger Hospital's psychiatric department was recently proposed to the District commissioners. It is hoped that the new salary plan will relieve an extremely critical personnel shortage. An emergency recruitment drive for 50 additional Gray Ladies has been instituted by the Red Cross to aid the depleted staff at Gallinger.

Capital Area Council Votes Confidence in H.S.A.

WASHINGTON, D. C.—A special committee has been appointed to report results of a study of pay scales of Washington hospital nurses and staff personnel, according to William R. Castle, chairman of the National Capital Area Hospital Council. The Graduate Nurses' Association has urged a recommendation in favor of a uniform salary scale for hospital nurses.

The council gave the Health Security Administration a vote of confidence in a recent meeting here and indicated that the function of H.S.A. should be continued. This agency was severely criticized in the Health and Hospital Survey released last month.

The council has been studying possible improvements in the contractual relationship between H.S.A., the Community Chest and the hospitals. A new contractual form will be submitted to directors and trustees of the various District hospitals for examination. Changes in the form would provide for greater independence on the hospitals' part and give them more responsibility in justifying applications for aid from the Community Chest.

O. V. R. Rehabilitates 123,422 Handicapped in Three Years

The Office of Vocational Rehabilitation, a part of the Federal Security Agency, has completed vocational rehabilitation of 123,422 physically and mentally handicapped men and women of working age during the three years of its operation, according to a recent announcement by Michael J. Shortley, director.

The average cost of rehabilitating a handicapped person, Mr. Shortley stated, is $300. This figure, he pointed out, is all the more impressive because it is a one-time expense—as contrasted with the recurring cost of from $300 to $500 a year which must come from public or private funds to maintain such a person in dependency.

Of the men and women rehabilitated into jobs last year alone, Mr. Shortley said, 79 per cent were unemployed at the time of applying for services and 18 per cent had never worked previously. Before rehabilitation they received wages and subsistence of approximately $12,000,000 a year from odd jobs, part time employment, relatives, friends or public support. After rehabilitation, they became self supporting, earning at the rate of $73,000,000 a year, an increase of more than 600 per cent a year. The average salary rate was $1764.

Two Institutes Held at Colby College

The second institute on hospital administration was held at Colby College, Waterville, Maine, June 18 to 20, in conjunction with an institute on nursing education. Registration totaled more than 30, with the two groups holding separate and joint sessions in conjunction with laboratory and question periods.

Directors of the institute were Raymond P. Sloan, editor of The MODERN HOSPITAL, and Elizabeth E. Bixler, R.N., dean, Yale University School of Nursing. The faculty comprised Miss Bixler, Mr. Sloan, H. Lenore Bradley, R.N., New York State Education Department, Albany; Helen Dunn, R.N., director, division of public health nursing, Maine Department of Health and Welfare; Joseph A. P. Flynn, chief supervisor, Maine State Bureau of Fire Prevention; Agnes Gelinas, R.N., chairman, department of nursing, Skidmore College; Dr. Frederick T. Hill, president, Maine Hospital Association; Dr. Claude W. Munger, president, American College of Hospital Administrators, St. Luke's Hospital, N. Y.; Edith Patton, R.N., assisant editor, *American Journal of Nursing*, and Frank Wing, director, New England Medical Center, Boston.

Pay Roll Tax Frozen Again

WASHINGTON, D. C.—The House Ways and Means Committee changed its collective mind July 13 about raising the pay roll tax 1½ per cent each on employers and employes. It has announced a decision instead to freeze the tax for another year at 1 per cent on employers and employes. The committee also eliminated in the Social Security revision bill the provision for larger grants to low income states for the payment of benefits to needy aged, blind and dependent children. The committee increased from $20 to $25 a month the amount the federal government will match with state funds paid to needy aged, blind and dependent children.

Dismiss State Hospital Head

Following the death of a coal miner from injuries sustained at Peoria State Hospital in Illinois in late June, Gov. Dwight H. Green removed Dr. Joseph Ellingsworth as director of the hospital and appointed Dr. Richard Graff, veteran employe of the state public welfare department, to the post. Dr. Ellingsworth denied that his dismissal had any connection with the patient's death.

U.S.P.H.S. Grants $50,000 for Cancer Research

WASHINGTON, D. C.—The U. S. Public Health Service has given approximately $50,000 in grants-in-aid to several universities for cancer research, it was announced here July 3. The National Advisory Cancer Council recommended the grants.

The University of Virginia received a grant of $15,000 to conduct a study of the fractionation of proteins of normal and cancerous tissues and of reactions to chemotherapeutic agents, under the direction of Dr. Alfred Chanutin. It also received a grant of $3550 for work to be directed by Dr. Robert E. Lutz on the synthesis of compounds causing cancer cell damage.

Two separate grants will be made to George Washington University. One provides for a study of the effect of vitamin E on the growth and incidence of spontaneous and induced tumors in mice, under the direction of Dr. Ira R. Telford. The other provides for a program of study under Dr. Chester E. Leesee of the toxicity, metabolism, physiological and pharmacological actions of substances that may be useful in destroying cancerous tissue.

Among others, the National Advisory Cancer Council recommended a grant of $10,000 to the University of Rochester for studies of gastric secretions in patients with cancer of the stomach. This program will be under the direction and supervision of Dr. John J. Morton.

The U.S.P.H.S. was recently granted $1,772,000 by a congressional committee to finance cancer research.

Health Insurance Bill Upheld by Becker

WASHINGTON, D. C.—Harry J. Becker, president of the Group Health Association here, who stated that he spoke not only for the Washington group but also for a number of other consumer-sponsored medical care organizations, declared his support for S. 1606, the national health insurance bill, in hearings on the proposed legislation June 25.

Mr. Becker maintained that, at best, voluntary plans can extend the principle of periodic prepayment of medical care to only a limited number of people. A national health program must embrace the health and medical care needs of all the people, he added. Only government can exercise the responsibility required in the planning, financing and administration of such a program for health.

The witness asserted, however, that *service* health insurance plans, as opposed to commercial and cash benefit insurance plans, should have a place in a national health program. S. 1606 as now drawn will foster the growth of those service plans already in existence, he believes.

The U. S. Chamber of Commerce, through its spokesman, Andrew T. Court of General Motors, is opposed to S. 1606.

Health Service Best on Local Level—Dewey

Local health service should remain in local hands, Gov. Thomas E. Dewey of New York stated at the annual convention of state health officers and public health nurses in Saratoga Springs recently.

"Local health service should progressively improve," the governor stated, "but this must be done under the major principle of home rule. The state can set standards, but I am deeply convinced that local health service should remain in local hands.

"If we were to transfer control of all health services to Albany, we would be destroying the very foundation of local responsibility and local participation. Government is no better than its roots, and its roots lie in every community of the state."

President's Welfare Reorganization Plan Goes Into Effect

By EVA ADAMS CROSS

WASHINGTON, D. C.—Part of the President's reorganization plan, moving a number of welfare agencies under the jurisdiction of the Federal Security Agency, went into effect at midnight July 15. The Chief Executive submitted this plan to Congress May 16 in order "to proceed as promptly as possible with the development of the Federal Security Agency to meet the postwar responsibilities of the government within its field of activity."

Among the agencies now under the administration of F.S.A., are: the *Children's Bureau,* except its child labor unit, the *Social Security Board* which was abolished as such but whose functions are transferred; the *vital statistics unit* from the Commerce Department; the *United States Employes Compensation Commission,* and St. Elizabeth's Hospital.

The Senate Education and Labor Committee is attempting to increase the annual allotment for child health services from $5,820,000 to $15,000,000; for crippled children, from $3,840,000 to $10,000,000, and for child welfare services, from $1,510,000 to $5,000,000.

Northwest Plan Offers Hospital, Medical, Surgical Care

Northwest Hospital Service of Portland, Ore., is offering a new comprehensive hospitalization, medical and surgical prepayment plan which became effective July 15, according to Frank F. Dickson, executive director. Features of the plan, according to the announcement, include free choice of doctor, no age ceilings, no physical examination and group enrollment through pay roll deduction arrangements.

The combined hospitalization, medical and surgical benefit coverage costs $2.10 a month for one person, $4.20 a month for subscriber and one dependent and $5.95 a month for family membership.

Celebrates Golden Anniversary

Fifty years old is the record achieved by the Englewood Hospital School of Nursing, Englewood, N. J. Commencement exercises held in June at which 30 nurses received diplomas climaxed a week of reunions, receptions and teas to commemorate the occasion. The school, founded by Dr. Mary Lord, has graduated 600 young women and one man. Eighteen of its graduates served in World War I and 87 in World War II.

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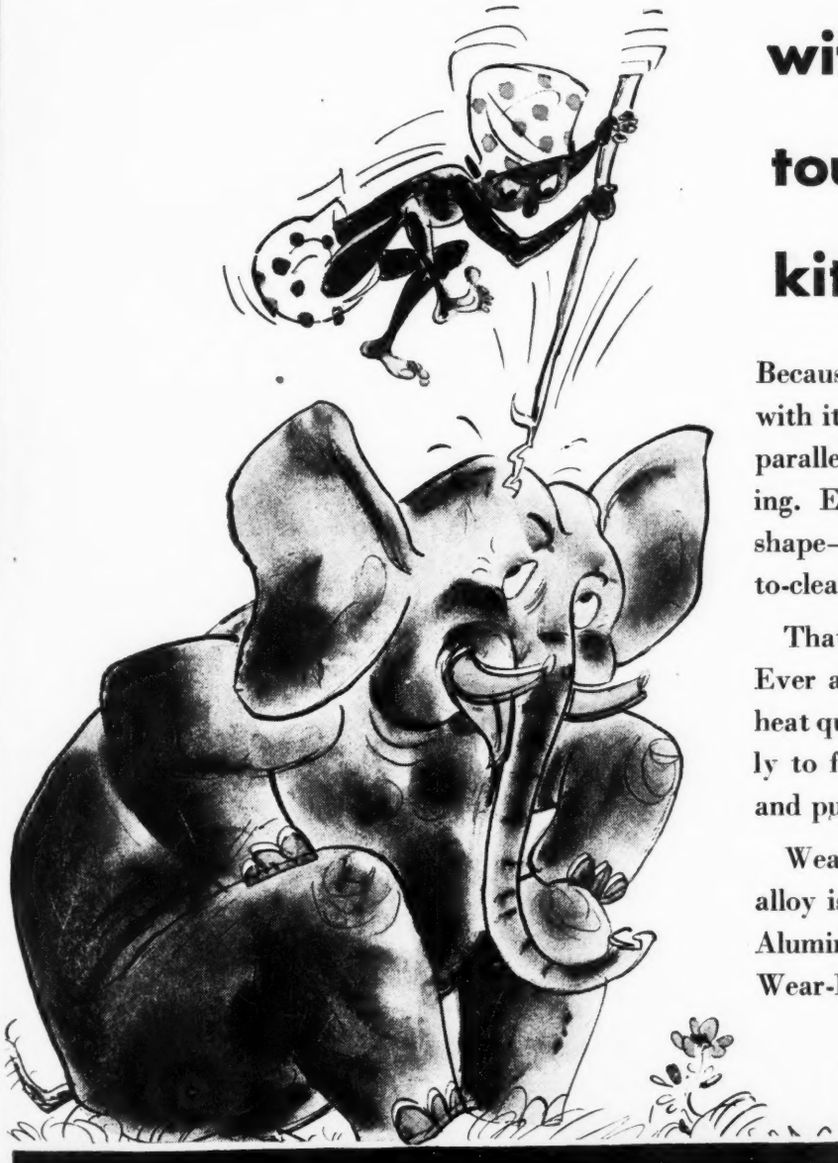

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Propose New Duties, Higher Rank for Army Pharmacists

WASHINGTON, D. C.—Pharmacists in the army medical department are slated for additional duties, more responsibility and higher rank if plans of Maj. Gen. Norman T. Kirk, the surgeon general, are approved. Legislation will be sought to organize a medical service corps which will place pharmacy, sanitary and medical administrative corps under one table of organization. Provisions are made for a pharmacist officer to serve in the office of the surgeon general.

Among numerous future duties, pharmacists will be qualified to serve in multitudinous hospital capacities as pharmacy officer, executive officer, adjutant, supply officer, mess officer, registrar, evacuation officer, hospital detachment commander and detachment of patients commander. They will compound and dispense medicines in units as large as general hospitals.

General Kirk stated that pharmacy officers will receive the same pay, emoluments and retirement benefits as are given to other officers who are of similar grade and length of service in the regular army.

C.P.A. Approves Hospital Construction Worth $7,411,563

Hospital construction valued at $7,411,563 was approved in 12 of the 71 Civilian Production Administration districts during the first two months of the veterans' housing program, the C.P.A. reported after a nationwide sampling of the construction jobs which had been authorized.

According to the report, during the first ten weeks of the construction limitation order new hospital construction and reconversion of old buildings amounting to $7,355,063 were approved in the 12 districts, along with an additional $56,500 for repairs.

A list of the 12 districts and the valuation of the approved hospital construction applications during this period follows:

Districts	*New and Reconversion*
Springfield, Mass.	$ 423,000
New York	130,250
Pittsburgh	108,000
Detroit	2,351,000
Atlanta, Ga.	641,890
Birmingham, Ala.	1,366,505
Chicago	1,137,318
Denver	155,000
Houston, Tex.	15,000
Los Angeles	455,600
Spokane, Wash.	000,000
Minneapolis	571,500
TOTAL	$7,355,063

Hospital Pays for Blue Cross Service for Its Employes

The entire cost of enrollment of employes and their families in the New Jersey Blue Cross plan is being borne by Morristown Memorial Hospital, Morristown, N. J.

Prior to July 1, when the new contract went into effect, the hospital's employes were enrolled on a voluntary basis and had the full cost deducted from their pay. Not more than 40 per cent were enrolled.

Robert G. Boyd, director of the hospital, declares that the net cost to the hospital will be around $1000 a year. This figure represents the approximate cost of maintaining the membership of the 40 per cent of the employes previously enrolled. Past practice had been to provide hospitalization for other employes and their families with little or no charge in most cases.

Ten of Memorial's 160 employes had been previously ineligible for Blue Cross enrollment because they are over 65. In view of 100 per cent enrollment, however, the Hospital Service Plan of New Jersey was able to include all employes without age limitation.

OFFICIAL ORDERS

Amendments to VHP-1:

Any conversion to nonresidential purposes which would cost more than $200 now must be authorized under the construction control order, C.P.A. said July 2. Other new provisions affect insulation, used materials used on the property of a prospective builder and certain trade fixtures.

Installing loose fill, blanket or batt insulation in existing buildings or installing mineral wool insulation on existing equipment or piping has been exempted from the coverage of the construction control order and may now be done without authorization.

The used materials exemption, under which the value of used materials was not included in figuring the cost of a job to see if it came within the small-job dollar value for which authorization is not required, has been tightened. Now the exemption applies only to used materials obtained without change of ownership.

Changes in the "Fixtures and Equipment" supplement include the restriction of the exemption for conversion of oil or gas burners, and stokers, to the exemption of these items only when they are used in connection with heating equipment already installed in a building. The exemption for storm windows and doors, screens and awnings has been enlarged to include venetian blinds.

Cottons.—Price increases for a number of cotton items were announced June 27 by O.P.A. Among items affected are two types of hospital draw sheets. Hospital draw sheets made from Type 140 unbleached sheeting, which are not included in the bed linen regulation, are being included in the major item of bed linens and given the same increase they previously received. Hospital draw sheets made from unbleached wide warp sateens are included in the major item of sheeting yarn fabrics.

Fire Extinguishers and Hose.—According to an announcement by W.A.A., large quantities of new fire extinguishers of different types and fire hose of various sizes are listed as government surplus commodities now available to all levels of trade throughout the country in continuing sales, in sales in progress or those about to be scheduled. Detailed information on these offerings and location of property can be obtained at any of the 33 W.A.A. regional offices.

The original number of units and the original cost to the government are as follows: New fire extinguishers in pump type, vaporizing liquid, carbon dioxide and foam in quantity of 600,000 units: cost to the government, $10,000,000. Fire hose of various sizes and unit lengths in quantity of 50,000 units: cost to the government, $1,250,000.

Hardwood Lumber.—Beginning August 1, no builder may use beech, birch, hard maple, oak or pecan boards or dimension lumber for framing, wall or roof sheathing, boxing, siding or subflooring in house, building or other structure, according to VHP Order 2 issued July 19 by C.P.A.

Plumbing Fixtures, limited to bathtubs, lavatories, kitchen sinks and water closets, have been added to Schedule A to PR 33. This schedule lists the bottleneck items on which no CC ratings are granted under PR 28, paragraph (g).

Priorities.—The Civilian Production Administration broadened its priority system July 11 to speed the production of certain electrical wiring devices, *i.e.* sockets, outlets and switches. PR 28 now grants rating assistance to manufacturers of selected electrical wiring devices.

Rubber.—Amendment 3 to Rubber Order R-1 effective July 9 authorizes natural rubber in increased amounts for various items. Among these are surgical tape and adhesive bandage. They will get an increase of 10 per cent natural rubber. Water bottles and combination syringes will get an increase of 15 per cent.

Sugar.—Small hospitals and other establishments principally engaged in care and treatment of sick persons, formerly Group 1 institutional users of sugar, may now obtain allotments as Group V sugar users, O.P.A. announced July 2.

This change was made because hospitals operating as Group 1 users have been particularly handicapped in obtaining sugar for preparation and service to their patients. They have had to obtain their sugar through the use of the ration books of the patients. It has often been impossible for such hospitals to obtain valid sugar stamps from the patients eating at the hospital. Moreover, entry into a hospital is often the result of an emergency condition and O.P.A. feels there should be no delay because the patient does not have valid sugar stamps in his ration book.

Tighten Regulations for Licensing Nursing Homes

WASHINGTON, D. C.—New and stronger regulations are being drafted by the District Health Department to extend the city's authority over such agencies as private nursing homes, private homes for the aged and convalescent centers. The present District licensing law does not include such private institutions.

Dr. Claude Munger in his hospital survey recommended that one of the early actions of the Metropolitan Health Council be a study of this problem. The law should be broadened, he urged, and standards should be formulated for the establishment of an inspection service that will enforce the whole plan. Health Department officials believe, however, that until the law can be broadened, much can be accomplished in the way of licensing and inspection by tightening the regulations under existing legislation.

Announce Plans for Four Institutes for Hospital Officials

Four institutes for hospital administrators and department heads are in the immediate offing or the immediate past: the fourteenth Chicago Institute for Hospital Administrators, Sept. 16 to 26; an institute on hospital personnel management in Chicago, held July 29 to August 2 and another on the same subject to be held at Stanford University, Palo Alto, Calif., August 26 to 30; the Institute for Medical Record Librarians, to be held in Cincinnati, August 26 to 30.

The institute for administrators and assistant administrators will have its headquarters at International House on the University of Chicago campus with applications considered in order of receipt. Registration fee is $20 for the twelve day session. Further information may be received from Dean Conley, executive secretary of the American College of Hospital Administrators, 18 East Division Street, Chicago 10, Ill.

Applications for the personnel institute in California, the fee for which is $50 complete, may be sent to the Council on Administrative Practice, American Hospital Association.

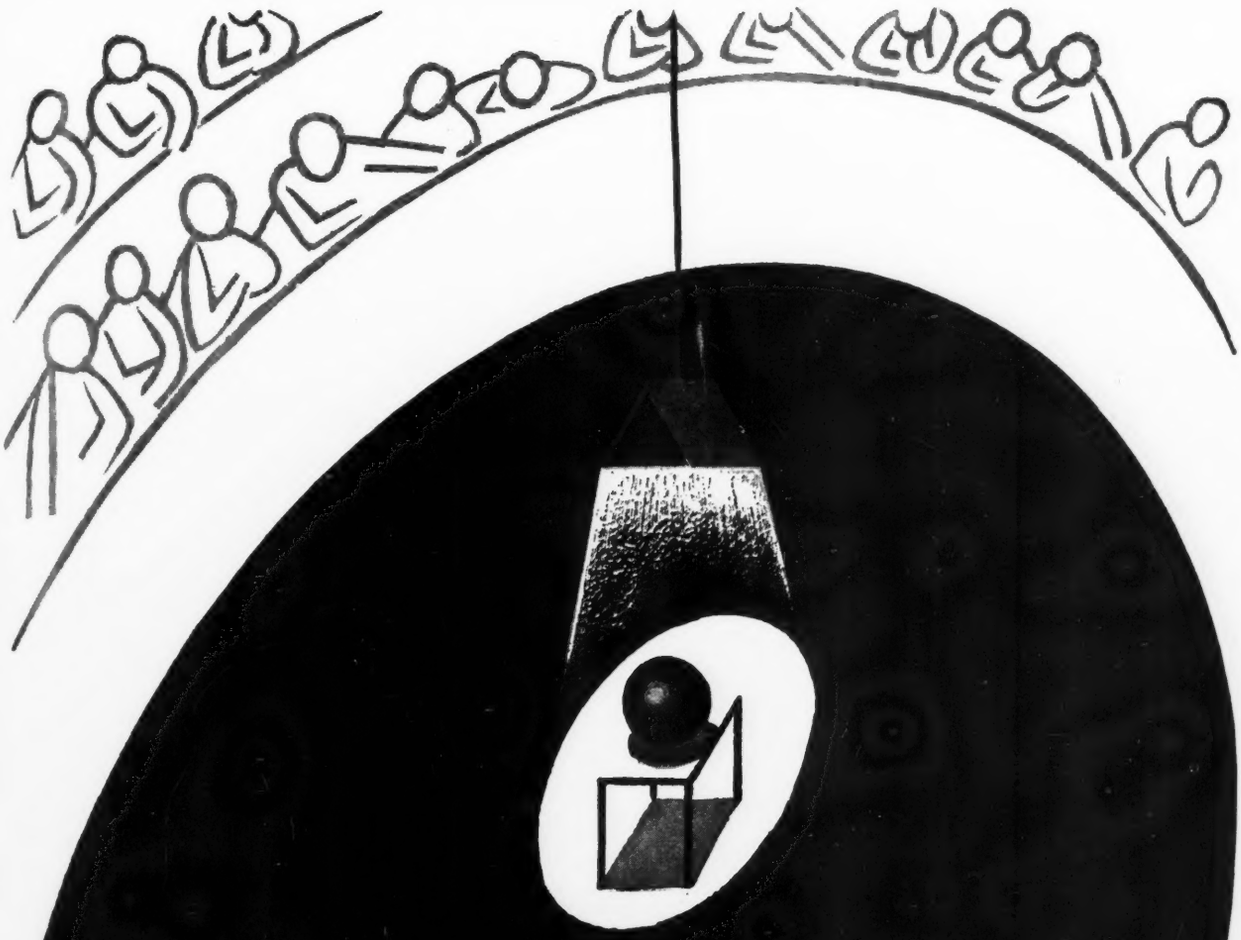
Blanks for the institute for record librarians (registration fee, $25) may be obtained from Dr. Hugo V. Hullerman of the A.H.A. or Mrs. Adaline C. Hayden, executive secretary of the American Association of Medical Record Librarians, both at 18 East Division Street, Chicago 10, Ill.

Continue Children's Fund Drive

Expected to reach the million dollar mark by early August, the building fund campaign for Children's Hospital of the District of Columbia will be continued throughout the summer in an effort to reach the $1,300,000 goal. Ketchum, Inc., of Pittsburgh, is conducting the drive which is expected to provide a new four story, block long structure to replace the 70 year old main building. York and Sawyer, New York architects, are drawing the plans. A feature of the drive is the large response in mail subscriptions following a broad program of press and radio publicity.

COMING MEETINGS

ALBERTA HOSPITAL ASSOCIATION, Palliser Hotel, Calgary, Nov. 6-8.
AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Philadelphia, Sept. 30-Oct. 4.
AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, Bellevue-Stratford Hotel, Philadelphia, Sept. 30-Oct. 3.
AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Philadelphia, Sept. 28-30.
AMERICAN CONGRESS OF PHYSICAL MEDICINE, Hotel Pennsylvania, New York, Sept. 4-7.
AMERICAN CONGRESS ON OBSTETRICS AND GYNECOLOGY, St. Louis, Sept. 8-12.
AMERICAN DIETETIC ASSOCIATION, Netherland Plaza Hotel, Cincinnati, Oct. 14-18.
AMERICAN HOSPITAL ASSOCIATION, Hotels Bellevue-Stratford and Benjamin Franklin, Philadelphia, Sept. 30-Oct. 3.
AMERICAN NURSES' ASSOCIATION, Atlantic City, N. J., Sept. 23-27.
AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC., Congress Hotel, Chicago, Aug. 12-14.
AMERICAN PHARMACEUTICAL ASSOCIATION, Hotel William Penn, Pittsburgh, Aug. 25-30.
AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Bellevue-Stratford Hotel, Philadelphia, Sept. 27-28.
AMERICAN SOCIETY OF HOSPITAL PHARMACISTS, Hotel William Penn, Pittsburgh, Aug. 25-30.
MARYLAND-DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION, Hotel Statler, Washington, D. C., Oct. 31-Nov. 1.
MISSISSIPPI STATE HOSPITAL ASSOCIATION, Edgewater Gulf Hotel, Edgewater Park, Oct. 17-19.
MISSOURI HOSPITAL ASSOCIATION, Hotel Jefferson, St. Louis, Nov. 29-30.
NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Morrison Hotel, Chicago, Feb. 12-13.
NATIONAL COMMITTEE FOR MENTAL HYGIENE, Hotel Pennsylvania, New York City, Oct. 30-31.
NATIONAL MEDICAL ASSOCIATION, Louisville, Ky., Aug. 19-23.
NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC., Atlantic City, N. J., Sept. 23-27.
NATIONAL SOCIETY FOR THE PREVENTION OF BLINDNESS, Hotel Pennsylvania, New York City, Nov. 25-27.
NEBRASKA HOSPITAL ASSEMBLY, Hotel Cornhusker, Lincoln, Oct. 21-22.
OKLAHOMA STATE HOSPITAL ASSOCIATION, Oklahoma City, Nov. 21-22.
ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 21-23.
PENNSYLVANIA HOSPITAL ASSOCIATION, Pittsburgh, April 23-25.
TEXAS HOSPITAL ASSOCIATION, Rice Hotel, Houston, March 27-29.



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Mental Health Group Launches Series of Radio Programs

To give the public a sound and sympathetic approach to mental illness, a series of four professionally produced radio plays will be launched by the National Mental Health Foundation.

Helen Hayes will introduce the first of two programs to begin in September. One series, known as "The Story of Louise Mapleton," will dramatize what can be accomplished in an efficiently run, well equipped state hospital for a person in an early stage of mental illness.

The second series, "The Case of Cynthia Edwards," will demonstrate the therapeutic possibilities of foster home care for a mental patient during her convalescent period.

The third program will deal with the almost tragic experiences of a fully recovered mental patient when he meets with the many prevailing prejudices in his own home town. The fourth will deal with the relationship between patient and attendant.

The first two programs will be open-end fifteen minute transcriptions. Local mental health societies and other sponsoring agencies will thus have an opportunity to make a locally pertinent message at the close of each program.

Organizations wishing further details may get them from Radio Section, National Mental Health Foundation, Box 7574, Philadelphia 1, Pa.

Outlines Plan for Department of Health

WASHINGTON, D. C.—A bill, apparently no specific part of President Truman's plan, was introduced in the House June 28 to establish a Department of Health. A member of the medical profession would head the department as Secretary of Health.

The following existing agencies would be transferred to the proposed Department of Health: the Food and Drug Administration; the Division of Vital Statistics; Freedmen's and St. Elizabeth's hospitals; the Children's Bureau, and all functions of the U. S. Public Health Service, Bureau of Narcotics and government of the District of Columbia Health Department.

The President would be authorized to transfer to the Department of Health at any time within 90 days after the passage of this act the whole or any part of any bureau, service or other agency of the government primarily engaged in fostering and promoting health and sanitation.

College Learns the Price of Peace

The first clinical congress scheduled by the American College of Surgeons since November 1941, which was to have been held in New York City September 9, has been canceled on account of the shortage of hotel accommodations, the college office in Chicago has announced. Every effort will be made to schedule the clinical congress for later in the year, the announcement said. Reason for the postponement was that attendance at the United Nations Assembly in New York in September, estimated initially to be 3000, is now expected to be between 6000 and 8000.

New Courses for Navy Nurses

WASHINGTON, D. C.—Five navy nurses began a twelve month course in anesthesiology July 1 at the University of Utah School of Medicine in Salt Lake City, Capt. Nellie Jane DeWitt announced recently. In line with the navy's announced policy of offering study in specialties to its nurses, this course, as are all others, is fully accredited. Other courses in anesthesiology will begin this fall at the University Hospitals of Cleveland and at Baylor University Hospital, Dallas, Tex.

Committee on Integration of Medical Services Reports to President

By EVA ADAMS CROSS

WASHINGTON, D. C.—With one exception President Truman approved and requested prompt implementation of all the recommendations contained in a report of his Committee on Integration of Medical Services of the Government. The committee, headed by Dr. Harold W. Dodds, president of Princeton University, was appointed by Mr. Truman last December. It was charged to make a study of the medical care provided by the various governmental services and to make recommendations for improvement in such services.

The President did not concur with the committee's recommendation to amend Public Law 346 to provide outpatient care to veterans with non-service connected disabilities.

Part I of the report dealt with the medical service in the Veterans Administration. Paying tribute to the high standard of medical service under General Bradley and Dr. Paul R. Hawley, the report made a number of specific recommendations for further improvement. Among them were the following:

That internships be established in Veterans Administration hospitals as promptly as the individual hospitals are recommended by the Dean's Committee and approved for internship by the American Medical Association.

That a joint committee of representatives of the Veterans Administration, army, navy and U. S. Public Health Service be appointed to study and make recommendations on a common system of medical records and disease nomenclature.

That the Veterans Administration initiate steps to improve the professional library service in V.A. hospitals and take the necessary action to obtain medical libraries that are now surplus in the army and navy hospitals.

Among hospitalization policies, the report recommended:

That for the acute and diagnostic problems of medical and surgical care of veterans with service connected disabilities, provision should be made for medical care in approved governmental and community hospitals, other than veterans' hospitals, in addition to existing facilities in veterans' hospitals for such care.

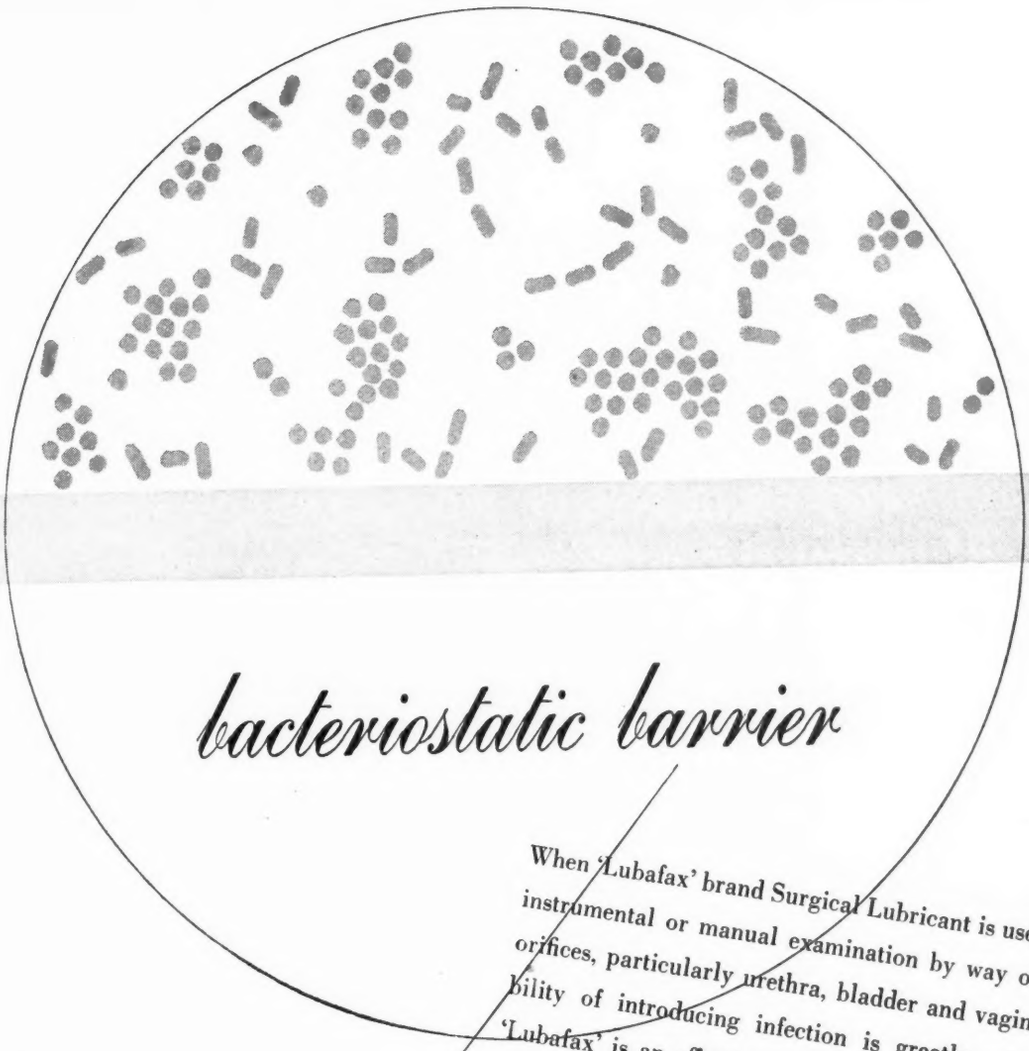
That the Hill-Burton Bill be promptly enacted and put into operation, that the amount of funds authorized be substantially increased and that the necessary priorities for building materials and equipment be granted in order that construction may proceed promptly.

Through enactment of the hospital construction bill, S. 191, the Veterans Administration can utilize the facilities of community hospitals supplementing its present building program. The committee pointed out the fact that if an adequate number of community hospitals is not provided, it will be necessary for the Veterans Administration to construct a much larger number of beds in all categories than would otherwise be necessary in order to meet the future hospitalization needs of veterans.

In Part II—Federal Medical Services—the report criticized the present method of providing medical care by a system of paralleling government agencies (army, navy, veterans' and Public Health Service) as inefficient, ineffective and extravagant. Each agency, for all practical purposes, now acts as a separate unit and competition for personnel and facilities is the rule.

There are many problems which are common to all these agencies, the committee declared. It recommended a study of the organization of the medical services of the federal government to determine whether a reorganization would permit the development of a more efficient system of medical care.

Before the medical services of the federal government can be reorganized,



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however, a complete and exhaustive survey of current medical resources is necessary, the committee claimed. The study should emphasize: (a) the development of a program of specialized training to supplement the present limited supply of specialists; (b) the development of a program of clinical and scientific research, research being an integral phase of the provision of a high standard of medical care.

A study of the possibility of integration and joint use of facilities and services should give particular attention also to: (a) purchase and supply; (b) procurement and assignment of personnel; (c) the training of physicians, dentists, nurses and other ancillary personnel; (d) uniformity of schedules of compensation, rating and promotion; (e) means for making the government medical services a more attractive career.

The committee drew the President's attention to the need for retaining in the medical services young physicians who had received all or part of their medical education at the expense of the government. It is believed these men should serve actively for a period equal to the length of training received under governmental auspices.

In addition to Dr. Dodds, the Committee on Integration of Medical Services of the Government is composed of: Maj. Gen. Howard McC. Snyder, Dr. Basil C. MacLean, R. Adm. Daniel Hunt, Dr. Charles W. Mayo, Dr. Howard A. Rusk, Chester I. Barnard and Dr. Thomas Parran.

Maternity Wards of Two Illinois Hospitals Closed by State

The maternity wards of two hospitals in downstate Illinois were closed by the state health department recently pending investigation of the causes of infant diarrhea. Sixteen deaths from the same ailment have occurred during the last year in St. Joseph Hospital, Alton, and St. Francis Hospital at Peoria, the health department reported.

Dr. Roland R. Cross, state health director, has asked the U. S. Public Health Service to work with state laboratory technicians in investigating causes of the diarrhea, which has occurred recently in several parts of the country and is similar in symptomatology to the disease which has stricken a number of infants aboard ships bringing G.I. brides and families to this country from Europe.

The afflicted infants become dehydrated, are unable to retain food, develop cyanosis and convulsions and then die. Authorities of the Alton and Peoria hospitals are cooperating fully with health department officers, the report stated.

To Train Psychiatric Nurses

WASHINGTON, D. C.—A program of instruction in psychiatric nursing will be established at the Brooke Medical Center at Fort Sam Houston, Tex., according to an announcement of the Surgeon General. Psychiatric nursing is to be made a part of the army nurse's basic education. For the first classes, however, preference will be given to nurses who are interested in psychiatric nursing as a specialty. The course will run for eight months and 25 nurses will be entered in each class.

$2,500,000 Modernization Fund

A total of $2,500,000 is being sought to modernize the National Jewish Hospital at Denver. Contributions from individuals throughout the country have been made to the hospital's building fund totaling $1,022,364, some of which has already been spent on the modernization program.

The institution expects to increase its capacity to 350 beds with an ultimate objective of 500 beds.

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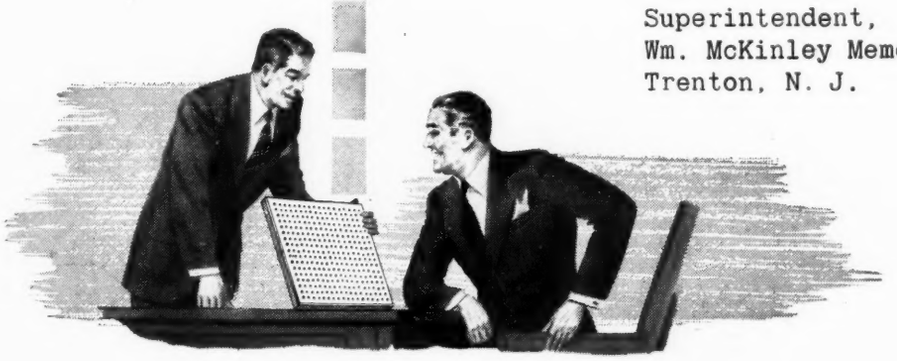

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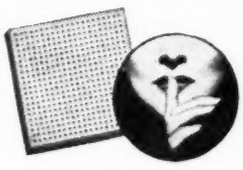

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ABOUT PEOPLE

(*Continued From Page* 84.)

John T. Bath, administrator of Bloomsburg Hospital, Bloomsburg, Pa., since June 1943, has resigned.

Capt. John C. Frazer of the navy's bureau of medicine and surgery is the new commanding officer of the hospital at the Great Lakes Naval Training Center, Great Lakes, Ill. He was senior medical officer on the *U.S.S. Repose,* hospital ship attached to the 7th fleet, and from 1943 to 1945 was in charge of the naval hospital at Key West, Fla.

Clarence W. Duryea, recently discharged from the medical administrative corps, has been appointed assistant to **J. Dewey Lutes,** superintendent of Yonkers General Hospital, Yonkers, N. Y. Before entering army service, Mr. Duryea was administrative assistant at Southside Hospital, Bay Shore, Long Island, N. Y.

Paul Cushing, business manager of Quincy Clinic, Quincy, Ill., has been named head of the new Providence Memorial Hospital, El Paso, Tex., a 200 bed general hospital not yet built. Before he entered the army, Mr. Cushing was business manager of Warmolts Clinic, Oregon,, Ill., and personnel manager of Dante Annex of Letterman General Hospital, San Francisco.

Louis Liswood, superintendent of National Jewish Hospital, Denver, has been elected chairman of the Denver Area Sanatorium Council for the coming year.

Dr. H. M. Maier has been named assistant medical director of National Jewish Hospital, Denver, **Dr. Allan Hurst,** medical director, announces. Dr. Maier, a native of Austria, was formerly assistant to the direcor of Workmen's Circle Sanatorium, Liberty, N. Y.

Rev. E. C. Hofius, superintendent of Lutheran Hospital, St. Louis, has been elected president of the Hospital Council of St. Louis. The Rev. Mr. Hofius is treasurer of the Missouri Hospital Association.

William W. Sheppard, formerly comptroller, has been named assistant superintendent of New Rochelle Hospital, New Rochelle, N. Y.

Russell Nye is on leave of absence from Dallas City-County Hospital System to do consultation and survey work with James A. Hamilton and Associates.

W. Conant Faxton, whose appointment as director of Margaret Pillsbury Hospital, Concord, N. H., was reported last month, reports that he will serve as joint director of the Pillsbury and the New Hampshire Memorial hospitals. The two institutions will combine and a new hospital is to be built on a site entirely separate from the present units.

Mrs. Eva Morris has completed her duties as superintendent of Brightlook Hospital, St. Johnsbury, Vt., and **Caroline C. Hatch,** former director of nurses, has been appointed her successor. **Charlotte Rawling,** Lockport, N. Y., has replaced Miss Hatch as director of nurses.

Mrs. Annie Riddell, R.N., superintendent of Lancaster Hospital, Lancaster, N. H., has resigned. She plans to rest and then return to private duty nursing.

Department Heads

Dorothy A. Hehmann has resigned as director of personnel at Grace-New Haven Community Hospital, New Haven, Conn.

Jeanette Fisher, R.N., assumed her duties as director of nurses at Dixie Hospital, Hampton, Va., on July 1. Miss Fisher was formerly director of nurses at King's Daughters' Hospital, Portsmouth, Va.

Elizabeth Flickwir, director of medical social service at Huntington Memorial Hospital, Pasadena, Calif., has resigned in favor of being a housewife. **May Mac-**

donald, a first lieutenant in the army nurse corps during the war, is the new director of the department. Miss Macdonald spent some months as nurse in the Buchenwald concentration camp.

Ruth K. Moser is the new director of nursing at St. Luke's Hospital, New York City, succeeding **Helene Olandt** who recently resigned. Miss Moser who has a master's degree in nursing school administration has been director of nursing at Geisinger Memorial Hospital, Danville, Pa.

Dr. J. Kuloski, recently relieved from active duty in the navy with the rank of commander in the U.S.N.R., has assumed his duties as full time chief surgeon at Carrie Tingley Hospital for Crippled Children, Hot Springs, N. M.

Miscellaneous

Ruth Freeman, associate professor of preventive medicine and public health at the University of Minnesota, has been appointed national administrator of the American National Red Cross Nursing Services.

Mabel Duncan Kirkpatrick has been named assistant director of psychiatric social work for the New York State Department of Mental Hygiene. Mrs. Kirkpatrick set up the After-Care Clinic for Psychiatric Patients at Washingon Heights Health Center, New York City, after which she became supervisor of social work at the Rome State Hospital school.

Dr. Edward Harvey Cushing, associate clinical professor of medicine at Western Reserve University, is the new chief of the division of eduation in the Veterans Administration department of medicine and surgery. He will work under **Dr. Paul B. Magnuson,** acting assistant medical director for research and education.

Dr. Harold Marks, recently released from navy service, is medical director of the Pierce County Industrial Medical Bureau, Inc., a prepaid medical insurance group to which more than 90 per cent of the county medical society doctors belong, and is administrator of the medical bureau's hospital which will operate at Tacoma, Wash., under the name of Doctors' Hospital. The bureau recently purchased Bridge Clinic and Mary Bridge Hospital for its work and has renamed them.

Lillian V. Salsman will fill the new position of director of nursing services for the New York State Department of Mental Hygiene which will centralize for the first time the department's nursing services in the various state hospitals. Miss Salsman recently concluded visits to mental hospitals in the United States and Canada studying methods of treatment, nursing care and psychiatric nursing education. From 1928 to 1934 she was superintendent of nurses at the American hospital in Moulmein, Burma, and helped train native women; for a time she served on the same mission board as Gordon Seagrave, author of "Burma Surgeon."

Virginia Scullin and **Arthur J. Bradley** have been appointed to the central staff of the New York State Department of Mental Hygiene as director of occupational therapy and supervisor of physical training, respectively.

Ruth Barnhart is the new executive secretary of the Texas Hospital Association, succeeding **Madelyne Sturdavant.** Previously Mrs. Barnhart was assistant editor of *Dental Digest,* medical record librarian at Charleston General Hospital, Charleston, W. Va., and medical secretary at the Mayo Clinic.

Samuel D. Cooper, R.E., and **C. Reginald Perry,** both members of the American Institute of Architects, have formed the firm of Cooper & Perry for the general practice of architecture and engineering and will be located at 204 Journal Building, Knoxville, Tenn.

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Hospital, Pittsburgh, has retired from the presidency of the board but continues as a member.

William Harding Jackson was elected president and **John Hay Whitney** vice president of the Society of the New York Hospital at a recent meeting.

Deaths

Emil M. Hauge, superintendent of Fairview Hospital, Minneapolis, died in early July while vacationing at International Falls, Minn. He was 59 years old.

V.A. Sets Up Mass Purchasing Plan for Hospitals

A mass purchasing and distributing plan to supply nearly 1000 hospitals and offices of the Veterans Administration is expected to be in full operation within another year, R. C. Kidd, director of supply service, announced recently. It is expected that the new plan will provide rapid, direct supply service to veterans' hospitals and will result in considerable saving to taxpayers because of mass buying and handling economies, Mr. Kidd said.

The plan provides for a constant flow of supplies to replace withdrawn hospital stocks and for the purchase of perishable items on a regional and local basis.

The Veterans Administration spends $50,000,000 a year for hospital supplies a volume which is expected to increase substantially as the number of veterans grows, Mr. Kidd stated.

O.T. Group Announces Meeting

The American Occupational Therapy Association will meet at the Congress Hotel, Chicago, August 12, 13 and 14, for its twenty-sixth annual meeting, its first nationwide convention in five years. Because of recent developments in physical medicine and because of the interest which the medical profession is expressing in the total field of rehabilitation, the meeting is expected to be of unusual importance.

Employe Health Programs

WASHINGTON, D. C.—A bill was introduced in the Senate July 10 to provide health programs for government employes. Heads of departments and agencies would, within the limits of appropriations made available, provide health services, by contract or otherwise, for employes under their jurisdiction. Such health services would be established only after consultation with the U. S. Public Health Service.

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W.A.A. Transfers Part of Camp for Use as Mental Hospital

WASHINGTON, D. C.—A portion of Camp Miles Standish will be transferred to the commonwealth of Massachusetts for use as a hospital for feeble-minded, War Assets Administration announced July 8. The area to be acquired by the commonwealth has an appraised value of close to $1,500,000 and will be transferred at a 100 per cent discount. About 400 structures are to be utilized for hospital purposes.

Massachusetts plans to spend more than $5,500,000 for the erection of new permanent structures on the site and anticipates that hospital facilities for a maximum of 3500 patients will be provided. At the present time, the state has public hospitals caring for approximately 5089 patients. There is a waiting list of 1200.

Urge Community Use of Army, Navy Hospitals

WASHINGTON, D. C.—Recommendations for transfer of 32 army and navy hospitals to community use have been made by the Office of Surplus Property Utilization, U. S. Public Health Service, at the request of the War Assets Administration, it was announced July 1. Numerous surveys were made by doctor-engineer teams of Public Health Service officers to determine where local needs could best be met by utilization of army, navy and Prisoner of War camp hospitals.

The recommended transfer will add 20,000 beds to the nation's total. According to Public Health Service criteria on hospital economics, such transfers will result in an accrued benefit to the nation of approximately 147 billion dollars.

60 Nations Sign U.N. Health Charter

Sixty nations signed the charter of the United Nations Health Organization July 22 after three weeks of meetings in which delegates had outlined the group's structure and functions. Signatories included the 51 member nations of U. N. and nine nonmember nations. Dr. Thomas Parran, surgeon general of the U. S. Public Health Service, has been named president of the international health organization.

Enrolls 500,000th Member

Wisconsin's Blue Cross Plan recently enrolled its 500,000th member. It now protects 3810 employed groups and is affiliated with 91 hospitals.

Ashford General Offered for Sale

WASHINGTON, D. C.—Ashford General Hospital, also known as the Greenbrier Hotel, in White Sulphur Springs, W. Va., has been declared surplus and is offered for sale by the War Assets Administration according to an announcement July 11. Purchased by the army from the Chesapeake and Ohio Railroad in 1942, the original reported cost to the government is listed at $3,317,441.80. Reports from the army corps of engineers indicate that subsequent improvements total something like another $2,500,000.

The nonindustrial portions of 26 other army and navy installations are in process of being advertised by W.A.A. for sale.

Navy Sets Up Polio Center

WASHINGTON, D. C.—Navy nurses are battling a polio epidemic in Key West, Fla., according to an announcement of the Navy Nurse Corps July 15. The naval hospital there has been made a polio center by the National Foundation for Infantile Paralysis. All cases of polio in Key West are being concentrated at the naval hospital. A poliomyelitis unit with all the latest known measures for treatment has been established.

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Glasgow Establishes Prevocational School for Nurse Students

After several months' operation, the prevocational training of girls for the nursing profession at Glasglow, Scotland, is reported to be progressing soundly and to have retained its full complement of 30 trainees who are 15 and 16 years of age. The scheme carries intending nurses over the gap between leaving school and starting probationary training during which period many prospective nurses are lost to other employments. The girls are retained at a separate training school, the Logan and Johnston School, for a period of one or two years, depending on the age of the girl concerned.

During the prevocational period, prospective nurses are given full preliminary training by lectures, demonstrations, visits and contacts with members of the nursing profession. They receive free uniforms, midday meals and traveling expenses. In the school, they have a complete laundry, laboratory, dietetic kitchen and a four room house. Visits to nurseries, nurses' hostels, nursery schools and other establishments are incorporated in the curriculum, as are such school subjects as chemistry, biology, anatomy, dietetics and physical training.

Although it is too early to claim any positive success for the plan, it is thought that a similar scheme for the entire country might be of assistance in solving one of the major recruitment problems of the present time.

Gives 420,565 Days of Care

A total of 420,565 days of providing patients with bed care is the new high set for 1945 by New York Hospital, New York City, which is this year observing the one hundred and seventy-fifth anniversary of the granting of its charter. The hospital's annual report, published by the Society of the New York Hospital, is the source of the information. The report shows that during 1945, the professional staff and specially designated technical experts carried on 174 medical research projects in New York Hospital and Cornell Medical Center. The hospital occupies 10 of the 15 units of the center; the Cornell University Medical College occupies the remainder.

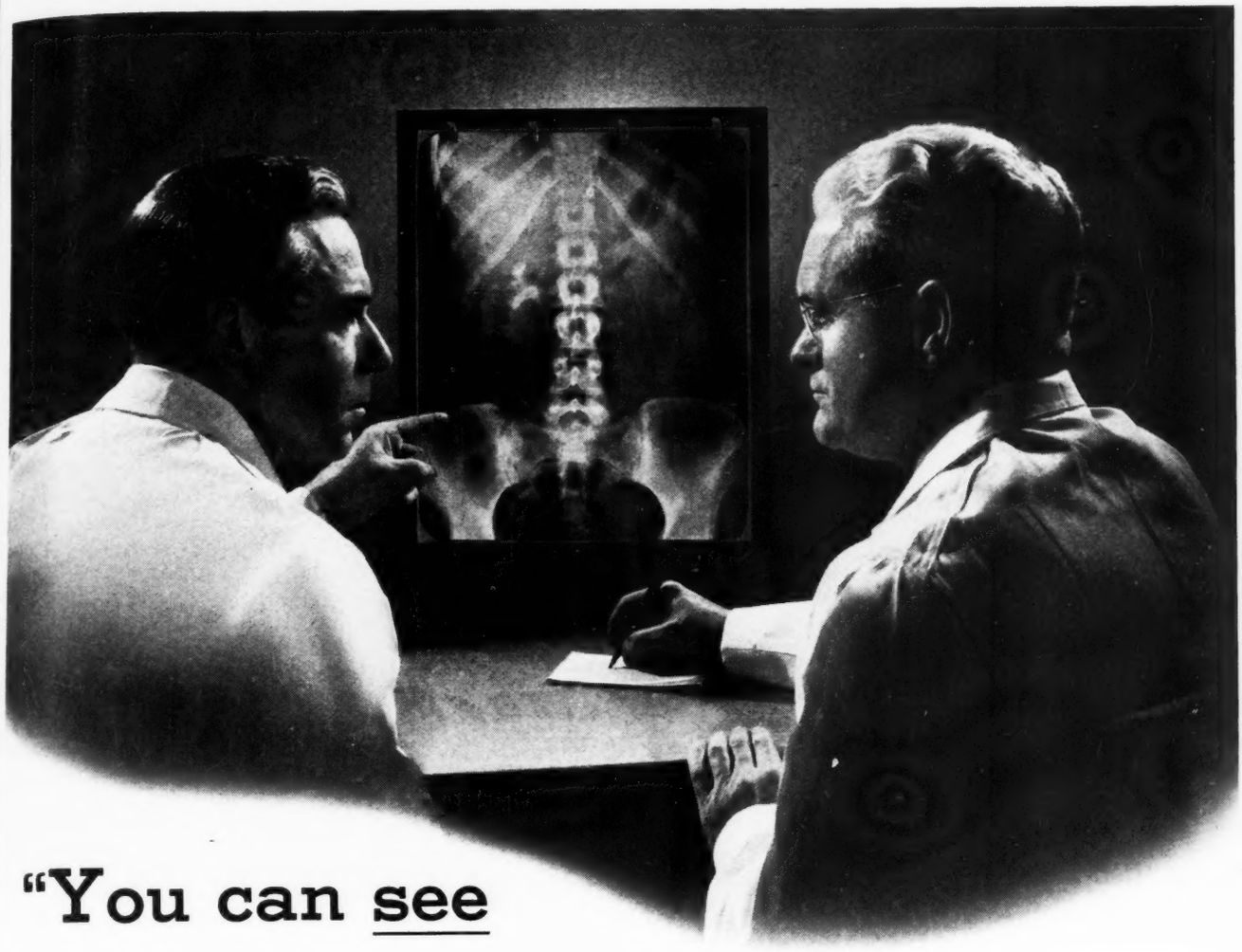
R. I. Plan Breaks Record

With the addition in June of 31,257 new subscribers, Blue Cross enrollment in Rhode Island shattered all previous monthly totals, according to Kenneth D. MacColl, president. The highest previous month's enrollment was 28,438 in November 1943. The total enrollment in Rhode Island is now 409,000, or 58 per cent of the eligible state population.

V.A. Sets Standards for Training Students in Clinical Psychology

WASHINGTON, D. C. — Representatives of 18 universities and officials of the Veterans Administration have worked out minimum requirements and standards to be used in training an initial group of 200 students in clinical psychology, V.A. announced in June. These students will be working for their doctor's degree in psychology while helping sick veterans. V.A. hospitals and mental hygiene clinics are in critical need of trained clinical psychologists. The V.A. training program was undertaken, in part, to meet this need.

The university representatives recommended that Public Law 293, 79th Congress, which set up a V.A. Department of Medicine and Surgery, be amended to include clinical psychologists in the same legal and professional status as doctors, dentists and nurses. They also wanted the Veterans Administration to offer positions for interns and residents in clinical psychology.



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Announce Plans for Army Research and Medical Center

Plans for an army medical research and graduate training center, which would be located at Forest Glen, Md., and which is expected to require twelve years to build, have been revealed by Maj. Gen. Norman T. Kirk, surgeon general of the army. It was announced also that the War Department will transfer the surgeon general's library of nearly 1,000,000 volumes, the largest medical library in the world, to a proposed new building on Capitol Hill near the Library of Congress and that it will be available for civilian as well as military medical use.

The research center, including a 1000 bed general hospital, would be erected on the site of the National Park College which was converted to a convalescent hospital during the war for Walter Reed General Hospital patients. The center would consolidate the army's extensive research activities and make them available throughout the medical field. Information obtained in army laboratories in the United States and Panama would be processed and filed at the research center.

Rare maladies would be studied by civilian and military scientists, and patients suffering from the diseases would be transferred to the medical center's hospital for treatment.

The first buildings to be constructed would house the general hospital and the army institute of pathology, established following the Civil War. Other proposed units include the army institute of research medicine and dentistry, army institute of research surgery and radiation therapy, army school of global medicine and a 250,000 volume research library.

The ground for both the research center and the surgeon general's library is owned by the army. No cost estimates are available as both projects are in the early planning stages.

The center would be designed to work in close cooperation with both veterans' and army hospitals.

Maine Hospital Heads Meet at Belgrade Lakes

Group conferences occupied a major portion of the Maine Hospital Association meeting held June 21-22 at Belgrade Lakes, Maine. This pattern of dividing the audience into small groups was successful in developing questions and discussions of individual problems. Some of the subjects selected for special attention were central supply rooms, accounting, pension and retirement plans, personnel practices, nursing service, records and the management of diabetic patients.

Participating in the general sessions were William S. Brines, superintendent, Malden Hospital, Malden, Mass., who discussed "Elementary Public Relations"; Rev. Donald A. McGowan of Boston, on "Trends in the Care of Chronically Ill and Long Term Patients"; Supt. Louette MacLeod, R.N., Camden Community Hospital, Camden, Maine, on "The Importance of the Admission Procedure to the Patient and His Relatives," and Dr. Jean A. Curran, president, Long Island College of Medicine, on "Medicine and the Changing Order."

In his presidential address, Dr. Frederick T. Hill, Thayer Hospital, Waterville, Maine, stressed the great need for developing and maintaining hospital spirit. This thought was further emphasized by Raymond P. Sloan, editor of The MODERN HOSPITAL, in an address at the annual banquet.

Dr. Hill is succeeded as president this year by Dr. Stephen S. Brown, director, Maine General Hospital, Portland. Frank E. Curran, director, Eastern Maine General Hospital, Bangor, becomes vice president and Pearl R. Fisher, Thayer Hospital, continues as secretary with Dan S. Thompson, Central Maine General Hospital, Lewiston, serving as treasurer of the association.

Shortage of Corn Threatens Manufacture of Medical Products

WASHINGTON, D. C.—Two officials of Merck and Company, manufacturers of, among other things, streptomycin and riboflavin, told the Senate Small Business Committee in June that the shortage of corn products is threatening the output of medicine. Effect on businesses of the government's purchases of corn and wheat for famine relief is under investigation by the Small Business Committee.

Merck has just completed a $4,000,000 plant for the manufacture of streptomycin, the purchasing manager testified. The plant is getting into production now and if dextrose is not made available, production will be interrupted. Dextrose, he explained, is used as one of the nutrients in the fermentation medium in which the mold growth is developed for streptomycin. It is also used as a raw material in the production of riboflavin.

Merck has a third requirement for corn derivatives, said the purchasing agent. It distributes dextrose USP and dextrose CP, as such, through pharmaceutical, drug, wholesale and hospital channels. The company has had no dextrose USP or CP for hospitals for some time, he claimed.

Hospitals Top Fund Goal

Surpassing its original goal of $700,000 by more than $43,000, the campaign to finance enlarging and modernizing of the Lewistown Hospital and the F. W. Black Community Hospital at Lewistown, Pa., ended in June. And work on the proposed projects for the two hospitals will begin as soon as sufficient building materials and labor are available.

Directed by the firm of Ketchum, Inc., of Pittsburgh, the campaign was first started in November and then postponed until April because of uncertain economic conditions. Charles R. Zook served as general chairman of the campaign which realized a grand total of $743,729.

U.M.S. Pays Obligations

"All obligations of the United Medical Service have been met in full," said Dr. Frederic E. Elliott, director of medical services, speaking before the Kings County Medical Society, Brooklyn, N. Y. "Contingent liabilities of the companies, which were merged to form U.M.S., to the amount of $50,000 have been paid off," he explained further, adding, "and there is a comfortable reserve to assure continued successful operation." Dr. Elliott lauded the medical profession for its whole-hearted cooperation and stated that there had been little abuse of the medical plan by either the public or the medical profession.

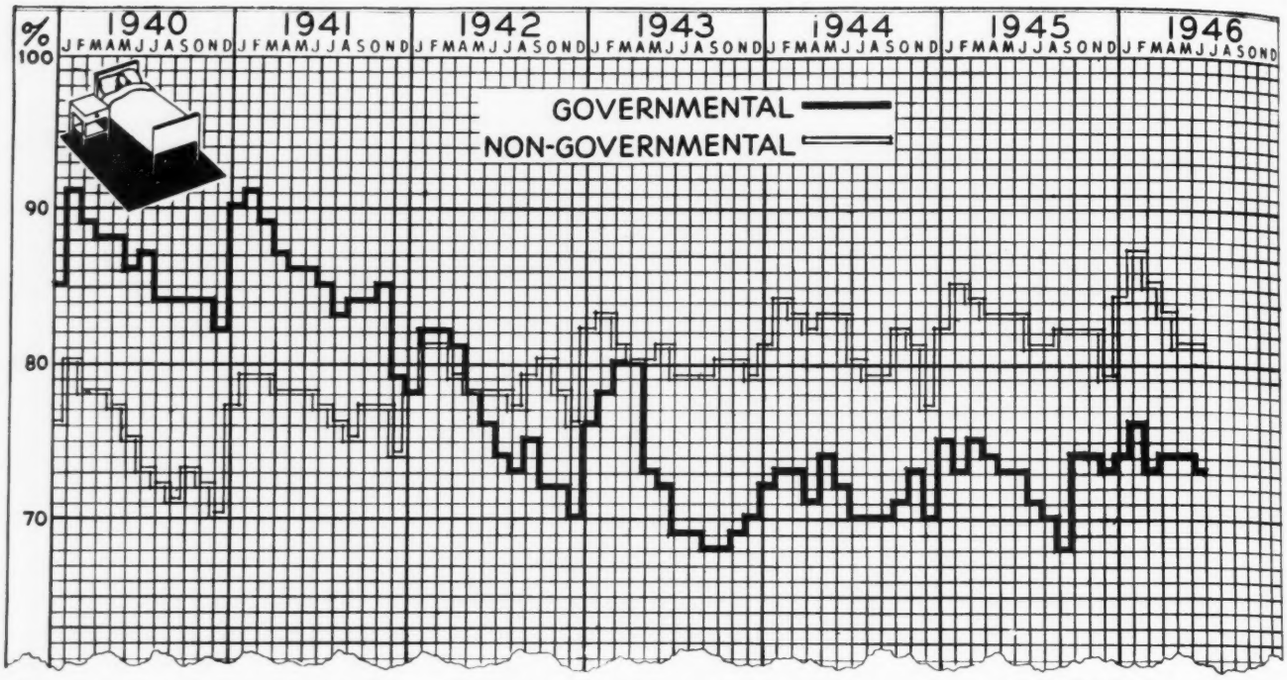
Nursing Groups Study Organization Structure

A representative structure study committee, headed by Katharine J. Densford, president of the American Nurses' Association, has launched a study of six national professional nursing organizations in an attempt to provide the nursing profession with a sound structural basis for its postwar responsibilities.

Raymond Rich Associates have been engaged to direct the study and to prepare an interim report for presentation at the biennial convention September 23 to 27. Funds are being contributed by individual nurses, friends of nursing and nursing organizations in the belief that any reorganization recommended will pay dividends in expanded service and stronger leadership.

Included on the sponsoring committee are representatives of the American Nurses' Association, National League of Nursing Education, National Organization for Public Health Nursing, National Association of Colored Graduate Nurses, Association of Collegiate Schools of Nursing and American Association of Industrial Nurses.

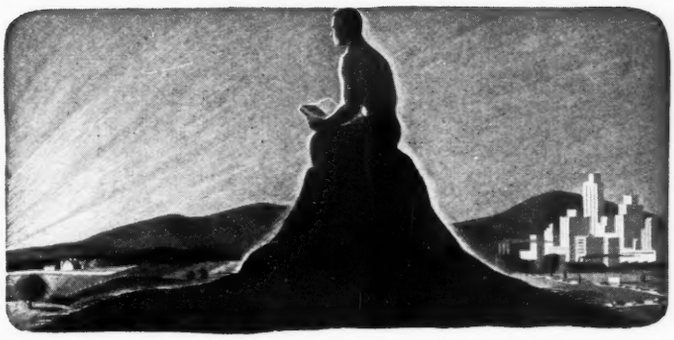
Construction Reports Highest for Year



Reports to the Occupany Chart from nongovernmental hospitals show occupancy at 81.1 per cent of capacity for the month of June—slightly lower than the same month a year ago. Governmental hospitals reported occupancy at 72.7—about the same as last June.

Construction reports for the last period are the highest for the year, totaling $53,092,712 and bringing the year's aggregate to $158,079,838. Among the new building projects reported are 22 new hospitals costing $28,725,384, and 57 additions to existing plants reported at a total cost of $22,979,915, or an average of a little over $400,000 for each addition.

Two of the reported projects were "alterations" totaling $269,000, and four projects were nurses' homes listed at $1,135,000.



AFTER HOURS

How Goot Is Business?

THE other day I stopped at a small florist's shop where I have been trading for years. During the course of my conversation with the proprietor, whom I had not seen for some months, I inquired how things were going.

"Fine, fine!" he replied enthusiastically. "You treat people goot, you all the time got business!"

Here, I thought as I left the shop, in a few simple words is the philosophy on which American business has been built. To the extent that business has "treated people goot," it has flourished. When it has neglected to treat people goot—sometimes involuntarily, to be sure, during these recent years of hardship—it has sickened or failed.

The last decade has seen the ascendency of the view that American business morals are bad and should be improved by the imposition of restrictions from without, that is, by law. Yet chiseling, gouging and profiteering are at an all time high today; black markets thrive; business morals have never been worse. Obviously, legislation does not produce the results its sponsors sought in terms of better business morals.

What is the answer?

During the course of thirty-five years of close association with most of the manufacturers and dealers serving the hospital field, I have watched a number of businesses grow from small beginnings into great enterprises. I have seen a few which seemed to offer promise fade instead into obscurity or oblivion.

By and large, I believe, those which have prospered have been those which treated people goot. Given time, character in business proves itself, just as character does in men and women —because, after all, business *is* men and women.

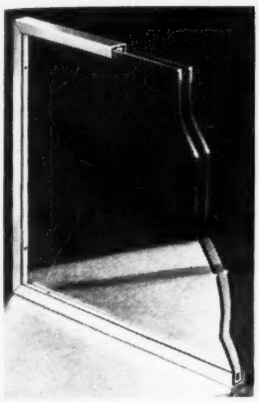
Competition produces better business morals, and better business, than legislation does. Sooner or later, this fact is bound to assert itself again in American life. In the hospital field and elsewhere, the business that has held fast to the principle of treating people goot has nothing to fear from the future.

—THE PUBLISHER

What's New for Hospitals

AUGUST 1946 SUPPLEMENT TO THE MODERN HOSPITAL

Insulating Window



A new type, double-glazed window with insulating properties has been developed and announced under the name Twindow. An integral insulating unit of two or more plates of glass enclosing a quarter inch or half inch hermetically sealed air space, the Twindow is framed with a light gauge stainless steel channel with the channel legs extending three-eighths of an inch inward on the surface of the glass to give maximum protection during installation and use. Hollow aluminum tubing is used to separate and hold the glass plates in position.

The new unit provides efficient thermal and dust insulation and virtually prevents condensation. Use of the units makes possible savings in winter heating and summer air-conditioning costs. **Pittsbugh Plate Glass Co., Dept. MH, 632 Duquesne Way, Pittsburgh 22, Pa. (Key No. 3200)**

Cory Buffet Queen Coffee Brewer

A new coffee brewing unit has been developed by Cory. Known as the Buffet Queen, the new unit should prove of interest in diet kitchens, nurses' homes and similar locations. The two burner unit features one burner with brewing heat on which the coffee is made and the other with warming heat on which the prepared coffee is kept at the proper temperature while a second brewer full is being made.

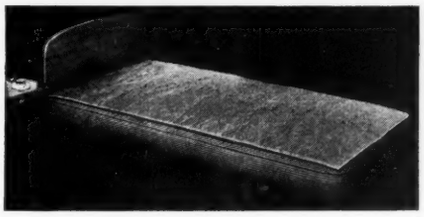
The unit consists of the burners with one brewer and an extra serving decanter. It has a serving capacity of 16 cups of coffee and is as attractive in appearance as it is practical in use. **Cory Glass Coffee Brewer Co., Dept. MH, 221 N. La Salle St., Chicago 1. (Key No. 3163)**

Disposable Blood and Plasma Filter

An impregnated nylon filter cylinder for use with blood and plasma has been developed by Baxter Laboratories. The new filter is designed to be used once and then discarded, thus eliminating the necessity of removing blood clots and otherwise having to clean cylinders for reuse, and the possibility of untoward reactions in blood recipients caused by improperly cleaned filter cylinders.

The ingenious pleated design permits the maximum filtering area and the filter is made for the inverted type of glass housing so that the entire filter can be submerged in saline before the blood passes through it. The new filters are supplied in individual packages. **American Hospital Supply Corp., Dept. MH, Merchandise Mart, Chicago 54. (Key No. 3143)**

Electrically Heated Bed Pad



A new electrically heated bed pad which eliminates the need for special heating devices, saves time and effort and keeps the patient's bed at an even temperature has recently been announced. This Therm-Aire pad is bed size, 32 inches wide and 72 inches long. It is made to be placed over the mattress and the bed made up in the usual manner. A small bedside temperature regulator makes it possible to maintain a constant mild temperature indefinitely.

The special waterproof and shockproof plastic coated wire which is used for heating is made of a new low temperature alloy such as was used in heated flying suits during the war. **Therm-Aire Equipment Co., Dept. MH, 1288 N. 4th St., Nashville 7, Tenn. (Key No. 3190)**

Improved Microfilming Equipment

The postwar models of the Recordak microfilming machines and viewers have been improved both in appearance and in operation. An automatic feed will be available on the RE Recordak and the signal and alarm systems to notify the operator if the film is used up, of improper location of the camera and if errors in feeding and operation have occurred have been changed and improved. The more positive alarm system saves time and materials.

The Duplex Recordak is designed to microfilm both sides of a document at the same time, side by side on the film. This is an entirely new machine providing all of the advantages of the other machines plus the simultaneous photographing of both sides of the document across the width of the film.

The film viewer has been streamlined and improved and it is now a simple operation for full sized prints of any document on a film to be made in a few minutes. **Recordak Corp., Dept. MH, 350 Madison Ave., New York 17. (Key No. 3148)**

Oxygen Hood for Infants

A clear transparent plastic oxygen hood has been developed for use with infants requiring therapeutic concentrations of oxygen. The hood is designed to fit any ordinary bassinet or incubator, completely covering the head and leaving the body accessible for nursing care. The hood is 9 x 11 inches in size, 6 inches high.

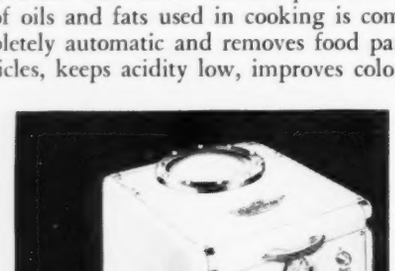
Oxygen concentration is accurately controlled by the injector meter which is standard equipment and there is provision for administration of penicillin

aerosol. **General Hospital Supply Service, Inc., Dept. MH, 256 W. 69th St., New York 23. (Key No. 3208)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 240

Fat Purifier

The new Model M-o Flavolator has been developed for use in smaller institutions. This device for the purification of oils and fats used in cooking is completely automatic and removes food particles, keeps acidity low, improves color,



flavor and odor and is economical because of the saving in fats and oils resulting from its use.

The new model is 15 inches wide, 16 inches long and 15½ inches high. It is easily portable and simple in operation with only two switches and one valve setting. The white enamel cabinet has a chrome plated lid and the unit is powered with a ¼ h.p. motor with a capacity of 20 to 30 gallons per hour. **Honan-Crane Corp., Dept. MH, Lebanon, Ind. (Key No. 3147)**

Wolfson Spur Crusher

The Wolfson Spur Crusher has been designed by Dr. William L. Wolfson of Brooklyn incorporating certain changes in this type of instrument. Both blades have large, evenly spaced saw teeth which interdigitate with each other. Any slight pressure of the jaws presses and fixes the intestinal septum barrier at multiple points, holding it firmly without slipping. Continued pressure stretches segments of the gut over the corrugated surfaces of the blades, thus permitting a quicker division of the septum. A firm, multi-locking unit is formed which does not allow any appreciable side slipping or end spread of the clamp. **J. Sklar Mfg. Co., Dept. MH, 38-04 Woodside Ave., Long Island City 4, N. Y. (Key No. 3150)**

Portable Audiometer

A new portable audiometer for use as an aid for measuring hearing loss has been announced. Known as the 6BP Audiometer, the new unit employs the superior circuit features used in the table model. It is housed in a simulated leather covered carrying case with recessed handle and a removable front cover. The face plate and dials are finished in black, thus increasing readability. The new unit also has other modifications and improvements which enhance its value. **Western Electric Co., Inc., Dept. MH, 195 Broadway, New York 7. (Key No. 3233)**

4500 Degree White Fluorescent Lamps

Where "warmer" than standard 6500 degree daylight lamps and "cooler" than standard 3500 degree white lamps are desired, the new 4500 degree white fluorescent lamps will prove effective. Available in 40 watt T12 and 100 watt T17 sizes, the new lamps are interchangeable with fluorescent lamps of the same wattage ratings now used in existing fixtures. **Sylvania Electric Products Inc., Dept. MH, Salem, Mass. (Key No. 3139)**

Beem Hospital Bed

The Beem hospital bed, which incorporates within itself most of the equipment needed for general nursing care, and which was described and illustrated on page 85 of the September 1945 issue of The Modern Hospital, to which the reader is referred, is now going into production and will be ready for delivery by the end of the summer, according to present plans.

The Beem bed is equipped with a control panel which can be placed within easy reach of the patient who has passed the critical phase of his illness and does not require constant supervision. Through this control board the patient can bring out an overhead bar which will aid him in moving about in bed; uncover and bring into position a flush toilet, the section of the mattress which turns back to uncover it containing toilet tissue; a lavatory with hot and cold running water and drains; an overbed table; an emesis basin with running water and drain and a large dressing table. All of these devices, of course, are returned to their unobtrusive places within the bed by another touch of the proper switch on the control panel.

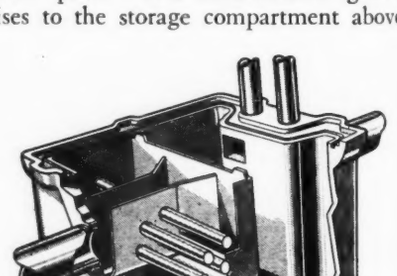
Also built into the bed are a top section which can be moved for transporting the patient, a cabinet for supplies and linens, retractable orthopedic posts and side boards, automatic control of the spring and mattress to give various positions, including Trendelenburg and rigid frame, retractable step for getting in and out of bed and a reading light. Each of these devices is brought into use or returned to its place in 35 seconds and the patient who can move freely in bed can take care of most of his needs without calling a nurse, thus saving a large amount of nursing time and preventing delays to the patient. **The California Darlington Co., Beem Bed Div., Dept. MH, 1336 Westwood Blvd., Los Angeles 24, Calif. (Key No. 3155)**

Detergent for Steam Cleaning

A new high speed detergent, Oakite Composition No. 92, has been developed for use in steam cleaning operations. It reduces time and cost in cleaning machinery and equipment parts, preparing surfaces for repainting and refinishing and cleaning equipment too large for tank immersion. Large hospitals should find this product helpful in the maintenance department. **Oakite Products, Inc., Dept. MH, 22 Thames St., New York 6. (Key No. 3192)**

Grease Interceptor

The Hydra Filter grease interceptor is a new, double-acting device employing a new principle of hydraulic filtering of grease by grease, in addition to conventional gravity differential separation. The grease laden waste passes through the hydraulic filtering element where the bulk of the grease is removed, then into the main body of the trap where conventional gravity differential separation takes place. The accumulated grease rises to the storage compartment above



and out of the way. It is clear, free from solids and commercially salvageable.

The Hydra Filter also permits handling of solids which are ejected through the trap into the drainage system. Other features of this new device include lightweight aluminum cover, special hand fasteners, moderate cost and high efficiency in operation. **Wade Mfg. Co., Dept. MH, Elgin, Ill. (Key No. 3154)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 240

Portable Cardiograph

The Portable Cardiotron is an instantaneous electronic cardiograph which traces its record of heart action directly on sensitized paper without photographic darkroom procedure. The minutest cardiac action is permanently recorded and visible the instant it occurs with this new machine which is simple to operate, light in weight and impervious to vibration and mechanical shock.

Weighing only 34 pounds, complete with accessories, the Cardiotron is easily taken to the patient's bedside. It can also be used to observe heart action during surgery and pharmacological investigation. The unit is encased in a handy carrying cabinet. **Electro-Physical Laboratories, Inc., Dept. MH, 25 W. 18th St., New York 11. (Key No. 3199)**

Mil-Du-Rid

A new colorless liquid has been developed for the prevention of mildew. Known as Mil-Du-Rid, the product is highly concentrated but when properly diluted it is safe for use on any fabric or any surface that would not be injured by soap or water, except those rubberized or waterproofed.

Mil-Du-Rid is designed to prevent mildew from forming in even the most humid conditions and can be used on clothing, rugs, furniture, draperies and similar items, on shoes and other leather goods, and in refrigerators, bread containers, garbage pails and other places where mildew forms.

Diluted with water, the product can be sprayed, wiped or mopped on the item to be treated. It is supplied in gallon containers. **Interchemical Corp., Dept. MH, 350 Fifth Ave., New York 1. (Key No. 3121)**

Disinfectant

SP-25 is the name of a new non-irritating, nontoxic disinfectant. Tasteless, odorless and harmless to users, their clothing and metals, SP-25, in proper solution, has exhibited speed in killing germs. It is designed for use in washing drinking glasses and food containers, for deodorizing and sanitizing food and beverage equipment, steam tables, garbage cans and other food handling and serving equipment as well as floors, walls, bed pans, operating rooms, shower stalls and other parts of the hospital.

In other dilutions the product is effective in combating mildew and molds and can be used for cold disinfection of surgical instruments. **Sethness Products Co., Dept. MH, 1300 W. Division St., Chicago 22. (Key No. 3205)**

Instant Sanka and Instant Coffee

A new Instant Sanka, the full flavored coffee from which 97 per cent of the caffein has been removed, is now available in one cup envelopes for institutional use. It can be used for making hot coffee instantly by merely adding boiling water to the contents of the envelope and iced coffee can be made by adding ice to the prepared beverage.

Maxwell House Coffee is also now available in instant form and can be made in the same way as Instant Sanka, either hot or iced. **General Foods Corp., Dept. MH, 250 Park Ave., New York 17. (Key No. 3194)**

Medical Charts

A series of medical and surgical charts has been developed by Dr. Samuel Weiss and produced by Medical Charts and Specialties Company. The new charts include a Non-Surgical Drainage Chart (microscopic findings) and one in color on the Diagnostic Significance of the Stools. **Medical Charts & Specialties Co., Dept. MH, 136 W. 25th St., New York 1. (Key No. 3189)**

Helio-Therm

The Helio-Therm Therapeutic Unit has been developed for radiation therapy. It is based on the artificial reproduction of every wave length from 2900 to 14,000 Angstrom units, including long wave ultraviolet, visible and short wave infrared energy, without producing erythema or other surface heat.

The units are furnished with one type "A" general purpose fused quartz applicator and extra 71 watt tungsten filament bulb equipped with on and off switch and cord for connecting to the electric outlet, A.C. or D.C. The unit is contained in a sturdy carrying case. **Aradio, Inc., Radiation Therapy Div., Dept. MH, Stamford, Conn. (Key No. 3195)**

Tweco Cable Splicer

A handy maintenance tool is provided in the new Tweco Cable Splicer designed for quick repair of broken cables or salvaging of short lengths. An efficient connection is assured with the simple clamp cable connection on each end of the splicer with provision to solder between the cable ends. The splicer is made in three sizes to cover the full range of welding cables. **Tweco Products Co., Dept. MH, Wichita 7, Kan. (Key No. 3203)**

PHARMACEUTICALS

Tridione

Tridione is a new synthetic anticonvulsant demonstrating a definite inhibiting effect on certain types of seizures in epilepsy. It also has analgesic and general anticonvulsant properties. It is supplied in 0.3 gm. capsules in bottles of 100. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 3127)**

Sulfonasol

Sulfonasol is a pleasant tasting, aqueous mixture of microcrystalline sulfadiazine in a specially prepared vehicle with flavoring, sweetening and coloring agents. It is designed especially for infants and children, and for adults who are medicine-conscious, and is indicated as an aid in the prevention and control of infections susceptible to the action of sulfadiazine. It is provided in 4 fluid ounce and one pint bottles. **National Drug Co., Dept. MH, 4663 Stenton Ave., Philadelphia 44, Pa. (Key No. 3245)**

Sulfadiazine-Aspirin Wafers

Chewing wafers of sulfadiazine and aspirin have been developed for the local treatment of infections of the mouth and throat caused by organisms sensitive to sulfadiazine. Known as Diazprin Wafers, they are available in boxes of 12, each wafer containing 5 grains of sulfadiazine and 3 grains of aspirin in a wintergreen flavored paraffin base. **E. R. Squibb & Sons, Dept. MH, 745 Fifth Ave., New York 22. (Key No. 3124)**

Thiouracil Tablets

Thiouracil 0.1 Gm. compressed tablets are available for use in the preparation of all types of hyperthyroidism for surgery and in the medical management of hyperthyroidism. The product must be used with great care because of complications which may arise in the use of this new antithyroid agent. It is supplied in bottles of 100 and 1000. **The Upjohn Co., Dept. MH, Kalamazoo 99, Mich. (Key No. 3213)**

Privine Jelly

Privine, the vasoconstrictor, is now available in jelly form. Easily carried in a pocket or purse, the new form is designed for patients whose condition is not severe enough to keep them confined. Privine Jelly contains Privine Hydrochloride 0.05 per cent in a bland, pine-scented water-soluble base. **Ciba Pharmaceutical Products, Inc., Dept. MH, Summit, N. J. (Key No. 3210)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 240

RECENT CATALOGS AND BOOKLETS

• **"Plastics for Light Conditioning"** is the title of a 12 page booklet describing the uses of plastics for reflectors and shades and published by the Plastics Divisions of the General Electric Co., Pittsfield, Mass. **(Key No. 3178)**

• Armstrong's new low cost utility flooring is described and illustrated in a folder entitled **"Armstrong's Accoflor,"** published by Armstrong Cork Co., Floor Division, Lancaster, Pa. **(Key No. 3269)**

• **Catalog** information on the complete line of Finnell scrubbers, waxers, polishers, mopping equipment, cleansers, sealers and waxes for maintenance of all types of floors is given in a four page folder recently published by Finnell System, Inc., Elkhart, Ind. **(Key No. 3253)**

• **Specification Sheet No. 608** on Whiting Stokers gives helpful information on the advantages of this equipment in coal saving, labor saving and other helpful measures for the heating system. It is issued by Whiting Stoker Sales Co., 11 S. La Salle St., Chicago 3. **(Key No. 3254)**

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it.

Bessie Covert,
Editor, "What's New for Hospitals"

☐ 3121	Mil-Du-Rid	☐ 3192	Detergent for Steam Cleaning
☐ 3124	Sulfadiazine-Aspirin Wafers	☐ 3194	Instant Sanka and Instant Coffee
☐ 3127	Tridione	☐ 3195	Helio-Therm
☐ 3139	White Fluorescent Lamps	☐ 3199	Portable Cardiograph
☐ 3143	Disposable Blood, Plasma Filter	☐ 3200	Insulating Window
☐ 3147	Fat Purifier	☐ 3203	Tweco Cable Splicer
☐ 3148	Improved Recordak	☐ 3205	Disinfectant
☐ 3150	Wolfson Spur Crusher	☐ 3208	Oxygen Hood for Infants
☐ 3154	Grease Interceptor	☐ 3210	Privine Jelly
☐ 3155	Beem Hospital Bed	☐ 3213	Thiouracil Tablets
☐ 3163	Buffet Queen Coffee Brewer	☐ 3217	Book "A"
☐ 3164	"Apparatus for X-Ray Therapy"	☐ 3222	Iso-Par
☐ 3166	Doehler Tubular Furniture	☐ 3233	Portable Audiometer
☐ 3170	"Stethoscopes by Pilling"	☐ 3245	Sulfonasol
☐ 3177	"Refrigerated Areas"	☐ 3253	Finnell Catalog
☐ 3178	"Plastics for Light Conditioning"	☐ 3254	Specification Sheet No. 608
☐ 3189	Medical Charts	☐ 3260	"Tri-Saver Coffee System"
☐ 3190	Electrically Heated Bed Pad	☐ 3269	"Armstrong's Accoflor"

I should also like to have information on the following products

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MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc.
919 N. Michigan Ave., Chicago 11, Ill.

• **"Apparatus for X-Ray Therapy"** designed and manufactured by Picker X-Ray Corp., 300 Fourth Ave., New York 10, is described and illustrated in a catalog recently published by this company. The profusion of photographs showing the equipment in actual use should prove of interest to hospital personnel. **(Key No. 3164)**

• The new line of **Doehler Tubular Furniture** is covered in complete detail in the 24 page catalog published by Doehler Metal Furniture Co., Inc., 192 Lexingon Ave., New York 16. This attractive, sturdy, long wearing line includes chrome plated furniture and equipment, aluminum furniture, baked enamel furniture, costumers, floor lamps, table lamps and smokers. As will be readily seen from the illustrations, this furniture should find a place in all types and sizes of hospitals as well as in nurses' homes. **(Key No. 3166)**

• An attractive booklet has been issued by Geo. P. Pilling & Son Co., Arch and 23d St., Philadelphia 3, Pa., entitled **"Stethoscopes by Pilling."** The complete line of stethoscopes is illustraed and described. **(Key No. 3170)**

• A new specification book of Truscon waterproofings, dampproofings and concrete specialties known as **Book "A"** has been published by Truscon Laboratories, Inc., Detroit 11, Mich. The book is divided into three sections for the three subjects covered and contains complete illustrations and descriptions. **(Key No. 3217)**

• An attractive brochure, illustrating and describing features of the new **"Tri-Saver Coffee System,"** has been issued by S. Blickman, Weehawken, N. J. The text is enhanced by diagrams and photographs which tell in detail the advantages of this system which eliminates the use of urn bags and filter papers. The "Sealweld Burnout-Proof" construction of these units is also described. **(Key No. 3260)**

• A pamphlet giving information on the use of **Iso-Par** in the treatment of anal and vaginal pruritus, mycotic infections and eczemas of the ear has been issued by Medical Chemicals, Inc., 406 W. Water St., Baltimore 2, Md. The product has acceptance by the Council on Pharmacy and Chemistry of the American Medical Association. **(Key No. 3222)**

• **"New Life and Efficiency for Refrigerated Areas"** is the title of an 8 page booklet giving pertinent information on proper air circulation for refrigerators as supplied by the Reco refrigerator fan. The booklet, No. 241, is issued by Reynolds Electric Co., 2650 W. Congress St., Chicago 12. **(Key No. 3177)**

Printed in U. S. A.